# Toward a Social Psychoanalysis of Rehabilitation Practice

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## Abstract

This article presents a social psychoanalytic reading of the rehabilitation clinic. I begin by sketching the basics of Freudian psychoanalysis, tempered with work by Parsons, Deleuze and Guattari, and more recent feminist critiques. In doing so, I outline the problem of developmentalism. I suggest that the problem of normative child development has already been addressed by critical rehabilitation research. By treating the clinical space as a space of desire, we can overcome normative models of child development, but still follow desire as it flows through clinical practice, its objects, and its residents. This applies to patients and practitioners alike. Looking to recent work on childhood rehabilitation, I examine three areas of critical scholarship where this social psychoanalytic framework supports critical research: individualism in client-centered care, living with disability, and, finally, death and dying. I address both psychoanalytic and sociological objections to this framework in the concluding section.

Keywords: Freud, Psychoanalysis, Rehabilitation, Childhood Development, Disability Studies

## Introduction

In light of recent work in the critical rehabilitation sciences, this article seeks to explore the rehabilitation clinic through a social psychoanalytic lens. I suggest that the foundational work of Freud, read through both classic sociological and more recent interpreters, gives us a lens through which to explore the rehabilitation clinic. Here I want to show why humanities-minded rehabilitation practitioners should care about psychoanalysis—albeit with some critical adjustment, as defined in this journal,[1] and explored below. I begin by giving a basic reading of Freud's work, then attending to the problem of developmentalism. While Freud's work does indeed chart personality development in problematic manner, other readings are possible. I then reconsider Freud's work with Deleuze and Guattari,[2] Parsons,[3] and feminist psychoanalysis.[4–6] This allows us to explore the clinical space as a site of object-relations, where social roles are accorded, and meaning is made amidst clinical agents. Here we can leave normative models of childhood development behind. Section three looks to recent work in humanistic rehabilitation practice, to show the purchase of this framework.



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## A FEW PROCEDURAL NOTES

I follow the three tenets of critical research introduced by Barbara Gibson.[1,7] Critical research must: (1) question taken-for-granted aspects of rehabilitation practice; (2) attend to power relations; and (3) critique the dominance of positivism in health research. Accordingly, I first question the often taken-for-granted categories of health, illness, and disability deployed in routine rehabilitation practices. They are an outcome—not simply the object—of caring practices. Care extends past medical practices, to the physical, emotional, and cognitive labor through which human lives unfold together.[8] Secondly, I consider the extra-individual social forces at work in the clinic—noting power imbalances, and mobilizing powers, at work in clinical practice. Finally, I ensure this exploration is anti-positivistic. I pursue collective energies, representations, and individuation, not an objective and statistically-verified comparative science of social forms. My focus is on finding meaning, not empirical falsification.

Some conceptual infrastructure is needed before my argument unfolds. In what follows, I use 'drives' and 'desires' to refer to the processes through which wants and needs are generated and satisfied. Drives and desires are generative insofar as they connect a want with a wanted object. Wants can be personal, in the case of a developing child wanting her mother; or collective, as in the case of a clinical team deciding on a therapeutic approach. Object choice, then, will refer to an object which is desired, and object-relations the greater structure within which this choice unfolds—clinical, emotional, or otherwise. These relations are affective because they shape the wanter and the wanted, in tandem. This shaping can be physical, emotional, or moral, but represent *shaping,* nonetheless. This focus on affect is in line with the work of Freud, Deleuze and Guattari, Parsons, and the feminist critiques of Freud, which I will outline below. Together, all of these thinkers find that the individual desired object undergoes a transformation in the desiring process. Individuals—humans and institutions—are shaped as individuals through these relations. Individuation is the process whereby individuals are shaped by their relationships with others. This process of becoming individualized reflects childhood psychosocial development, as well as the operation of the rehabilitation clinic, as we shall see below.

Finally, and following the Spinozist understandings of power that pervaded 20th-century French philosophy, I use power in the twofold sense, in reference to both mobilizing capacities (*puissance*), and overt decision-making (*pouvoir*). Desire is powerful insofar as it shapes those who want, and the objects to which they are driven. Both senses are essential to capture the micro-politics of clinical life, to chart at once the individual affects and the collective politics of healing. In the following section, I show how this takes us from Freud's restricted focus on psychosexual development to the politics of the healthcare assemblage as a whole. I do not want to abandon Freud, rather extend his insights in new ways.

## Freud, Desire, and the Problem of Developmentalism

Freud is a deterministic theorist of human drives.[9] In this deterministic approach, sexuality is understood as a process through which desires are generated and satisfied through our relations with others. From infancy on, individual personalities are the outcome of psycho-sexual development. Desiring attachments begin in infancy, in the infant-mother dyad, and are over-coded in successive life stages, to include the



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greater family structure, and then successively abstract social roles from that foundational institution. Freud sees the development of personality emerging through a broad caring structure, first found in the satisfaction of desires in relation to the mother, then the family, and then—following the oedipal period—to other persons and things to which needs and wants are affixed. The entirety of a human life can be thought of as the ongoing process through which particular modes of object-cathexis unfold. The early theorization of conscious-versus-unconscious desire structures, however, would become enveloped in Freud's famous Id-Ego-Superego structure. Here the id (our unconscious and basic desires) encounters the ego, (the personality, itself reigned-in by the super-ego, primarily the moral agent of 'reality testing.') In either formulation, the earliest relations of childhood sexuality take center-stage.

My first emphasis is on *care*, a relational practice through which we cultivate ourselves and others. In contrast to a strict reading of *health*care, Freud sees the development of personality emerging through a broad caring structure, in psycho-sexual development. Care and desire go hand-in-hand in such a framework. Whereas Freud's career-long focus on childhood sexual development emphasized the earliest relations of childhood sexuality—through the oral, anal, and genital phases, and in relation to the care-structure of the family—my focus here will be on how desires are mobilized clinically.

### FREUD AND PERSONALITY DEVELOPMENT

'The problem of developmentalism' unfolds as follows. Freud suggests that for healthy personality development, we must move from a particular set of objects to others. The healthy infant first establishes oral satisfaction with the mother's breast. The child then re-affixes desires to various other somatic components, in progressive stages of psychosexual development. The structure of the nuclear family is an essential component, and the source of most psychological pathologies in instances of regression. Pathological manifestations are, ultimately, traceable to a deviation from this developmental schema. Thus, the point of psychoanalysis, to restructure psychic energies, bring past trauma to light, and overcome repression. In bringing this trauma to light, the analyst becomes the object of 'transference.' "By this we mean a transference of feelings on to the person of the physician."[9] This can take a positive or negative form (lust or aggression)—but in either instance, libidinal attachments are re-affixed in the therapeutic encounter. This offers the skilled analyst the opportunity to find and restore the pathological trajectory taken by the patient's psychosexual development.

In both normal and pathological forms, Freud presents us a roadmap of healthy development, a path which many of us do not follow. Which bodies, and which personalities are exceptional to this mold? The choice is to treat all deviations as pathological, *or* to abandon the implied notions of normalcy within the psychoanalytic framework, while still retaining the emphasis on object-relations. This is the problem of developmentalism. I aim to address it with some unlikely allies: Deleuze and Guattari, on the one hand, and Talcott Parsons on the other.

## Unlikely Allies

### DELEUZE AND GUATTARI

In their *Anti-Oedipus,*[2] philosopher Deleuze and radical psychoanalyst Guattari attempt to overcome a merely epistemological and psychological reading of Freud,



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evoking a 'materialist psychiatry.' Rather than diagnose pathological personal forms found in childhood trauma, like Freud, they wish to do a desiring-analysis of social forms—particularly of capitalism. The object-relations that Freud found underpinning sexual development and desire, Deleuze and Guattari argue, are those same object-relations flowing through Marx's analysis of economic forms in *Capital (Das Kapital)*.[10] They mobilize powers of acting, shape our subjective existences, and, the authors argue, are candidates for critical political evaluation. The oedipal triangle, they suggest, is not universal but rather historical: it takes the bourgeois family as the model on which all personalities and social structures develop. They suggest, however, we look to all economic and psychic reality through a framework of desiring production—as much historical as it is natural. I suggest that by looking to economic and psychic production through the same historical lens, we can distance ourselves from the problem of developmentalism and move to a critical analysis of the social relations that shape human life. The focus on object-relations remains, but without an exclusive and historically-ignorant determinism that produces a norm and simultaneously marginalizes atypical personality and bodily development.

## PARSONS

Talcott Parsons initially read Freud as a window into the role of professions in medical practice—particularly the social roles of analyst and patient as comprising a functional social system.[3] Freud offered a psychological component to the analysis of *motivation*, which Parsons read as very compatible with his general theory of action.[11] Here I pass over Parsons's comprehensive but textbook reading of Freud and focus instead on developmentalism. Parsons attends to the problem of developmentalism in two ways. First, Parsons questions the extent to which the id, ego, and superego are socially structured. Freud seems to restrict the moral dimensions to the ego and superego, with the latter (superego) performing the reality-testing function on the former (ego), itself making sense of the drives of the id. Freud's metaphor of the ego and the id is of a rider on a horse, reigning in desires and occasionally failing at this task. This suggests an internal psychic system, and an external reality that the system incorporates. Parsons disagrees. The individual, too, is the outcome of a moral order, one varying in different types of social structures—Parson's 'sick' role being a prime example, referring to the social roles and responsibilities given to the patient during illness and recovery. Parsons argues that pattern maintenance is an essential element of all the actions of the ego and superego. That is, one must have a consistent and generalizable account of 'the real' and of oneself in order to partake in oriented social action. This account is generated institutionally, through defined social roles—the family being one instance of a social institution with accorded roles, and the school class another. The patient-practitioner dyad, finally, is the one preferred by Parsons in his medical sociology.

## CONVERGENCE

I believe Parsons's social roles are similar to the emergent, flowing, and temporary understanding of subjectivity we find in *Anti-Oedipus*. Social roles are established in relation to desiring bodies, are institutionally substantiated, relate to material aids, and—most importantly—are temporary, multifaceted, and relate directly to the same clinical experiences. Deleuze and Guattari see the individual desiring body as an outcome of desiring forces, arrested for an instant to form a temporary unity. So, for example, Gibson[12] finds that individual disabled persons exist as they do with other forces, be they a ventilator, a care attendant, or a companion animal. They are individuals *because*



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they form linkages with other human and nonhuman forces to dwell in the world. On the practitioner side, we could think of the technical aides used to measure and assess function. In either case, they are *individuated,*[13] whereby individual properties emerge through relationships with others. One looks back upon a day of work or clinical treatment and says, "so that's what it was."[14] This is the individual clinical subject, for but a moment. If one accepts that social roles and subjectivity are, in fact, similarly generated, then we can read them together.

## Much-Needed Feminist Critiques

After reading the above men, we are left wanting for critical feminist takes on psychoanalysis. Looking to the work of Herman, Grosz, Ahmed, and Butler meets these needs.

### HERMAN

Written from a feminist perspective, Herman's *Trauma and Recovery*[15] historicizes Freud's early work into hysteria against the political backdrop of 19th-century France. Charcot's work at the *Salpêtrière*, of which Freud was a member, set the stage for the "heroic age of hysteria," whereby Freud, Breuer, Janet, and other men waging war on hysteria were simultaneously fighting a battle between the secular bourgeois and clerical forces. Women's bodies were the battleground, and these inquiries had led the investigators to the reality of gendered trauma. By the 1900s, however, that war was over, those bodies claimed by medicine. Now "there was no longer any compelling reason to continue a line of investigation that had led men of science so far from where they originally intended to go. Certainly, they had never intended to investigate sexual trauma in the lives of women."[15] Herman shows us that Freud's abandonment of hysteria did not simply occur because of his lack of faith in hypnosis, as he later claimed, but also because of the *political* consequences of his discovery. The forgotten history of hysteria is, in fact, the unacknowledged history of sexual violence, and the scientific abandonment of those so subject. Like Herman's exploration of trauma, I wish to explore the clinical space through psychoanalytic concepts. We can, she rightly shows, investigate psychic energies in far less bigoted and traumatic ways than these careless pioneers.

### GROSZ

Grosz's *Volatile Bodies* provides a comprehensive reading of Freud's later work through a critical feminist lens.[6] She, too, addresses the problem of developmentalism, through the metaphor of the mobius strip. That is, her corporeal feminism seeks to understand how psychosexual desires emerge at once within and without the desiring body, in- and out-folding like that strip. Freud offers an "inside-out" companion to Nietzsche and Foucault in this task, both offering analysis on the shaping of the flesh from without. By doing so, Grosz wants to turn attention to the gendered power dynamics flowing through the body—something of crucial importance to the politics of rehabilitation. She, like Judith Butler, demands we look to the *sexed* body in its collectively-assembled embodiment in her corporeal feminism. Reading Deleuze and Guattari, too, Grosz asks us to look at the development of multiple sexualities—"a thousand tiny sexes" as she puts it—as spaces of desire and psychosocial development as a whole.[16] Whereas Freud has a single, heteronormative, ableist, and, I would argue, bourgeois familial model through which the human being undergoes psychosexual development, Grosz offers us the ability to pursue other lines of flight, and to recognize the institutional powers at work in our mutual embodiment. She offers a gender-and-



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sex sensitive critique of a normative development, a pluralistic alternative, while still accepting the mobilizing and mobilized powers of desire. As with Butler and Ahmed below, she offers a feminist alternative to Freud's rigidity.

## AHMED

Ahmed's *Queer Phenomenology*, too, provides a phenomenological critique of Freud's writing, on "the lesbian phallus," and in other adjacent, heteronormative concepts.[5] The project of Queer Phenomenology is a cultural phenomenology: how bodily orientations take shape in the shared world. Ahmed asks how our orientation to *things*, *desiring bodies*, and *racial identifications* lend themselves to phenomenological analysis. Freud's normative model of psychosexual development is, she argues, a *straightening device*—one that aligns bodies to a particular path, and makes astray desires deviant, or makes them disappear. His regrettable remarks on the lesbian physique attest to as much. The concept of the straightening device, on the institutional spaces that direct bodily orientations, is more than simply an indication of Freud's deficits. It also offers us the ability to explore which (gendered, sexed, or racialized) bodies are made desirable, and how collective orientations shape this process. Ahmed does not address disability in her work—but she easily could. The tools are there.[17] Regardless of which type of bodily orientation we explore, to *queer* Freud is to rethink the desiring economy in affirmative ways. It is to offer, in part, a feminist alternative to the problem of developmentalism without rejecting psychoanalysis as a whole.

## BUTLER

Finally, for my threefold annotations of psychoanalytic feminisms, I turn to Judith Butler. Butler's work on the materiality and performativity of sex and gender norms is clearly of interest to those who would explore childhood socio-sexual development. "The matter" of the body is at once ethical and material—a political site of desire and contestation. This point has already been made, and made often, in the critical rehabilitation literature.[18,19] To supplement this existing research, I would point to recent psychoanalytic work Butler has done on framing and "grievability," on the one hand, and her recent critique of individualism on the other. Exploring the politics of grief, Butler asks us a simple question: For whom do we grieve? Which are the lives that we value, as global citizens, and how do we frame those lives that we must mourn?[20] Here, Butler's objects of choice are the subjects of warfare, and how state violence coalesces with the politics of belonging. Mine are the subjects of rehabilitation. What kind of life do we promote in clinical rehabilitation; what bodily matters are within the scope of the clinical enterprise? Ultimately, who decides? Butler reminds us that the human body is the beginning and end of all politics, of pertinence to both enterprises. The conscious and unconscious aspects of grief bring us from a discussion of psychic trauma and its psychoanalytic exploration to questions of belonging, and of unequal access to it—in each case originating and returning to the desiring body. The politics of grief are a question of desire, and of collective representation.

Butler's most recent book asks us to evaluate violence through her politics of desire.[21] "Violence" here refers not only to explicit acts of harm, but to the framing of particular agents *as* violent; how such framings can be injurious, and consequently display the form of life valorized in liberal democracy today. Symbolic violence, structural violence, state-sponsored violence: we need a non-violent response that meets the demands of each form. Non-violence is not simply a



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pacifist opposition to violence in all its forms, but an active and ongoing set of somatic techniques used to affirm *life.* in our shared attachment to one another. Butler's aim is an ethics of attachment beyond patriarchal liberal individualism—for this individualism involves an unconscious avowal of the individuation I highlighted above. Illusions of original, natural self-sovereignty (as in the Hobbesian escape from the state of nature) and the generative, gendered bourgeois symbolic roles taken for granted in Freudian psychoanalysis, either consciously or subconsciously obscure the care relations and potential obligations arising from our interdependency.

I look to Butler's more recent work for three main reasons. First, it is worth reading. Second, she, like Herman, Ahmed, and Grosz, provides a productive critique of psychoanalysis, and extends it in new and novel ways. Finally, she moves us to the realm of cultural production, like Deleuze, Guattari, Parsons, and her feminist collaborators. Psychoanalysis is not, simply, a theory of human development—one that originated in the study of pathological phenomena and became a theory of psychosocial development. All of this is indeed the case, but it is not the only reading.

### PSYCHOANALYSIS AS AN EXPLORATORY TOOL

We can also use psychoanalysis to look at the conscious and unconscious ways we organize our lives in concert. We can use it, with some adjustment with feminist theory, to include forms of embodiment previously deemed pathological. And, most importantly, we can use psychoanalysis to explore the forms of personhood that take shape in institutionally-sanctioned care practices (as well as those that do not). Butler, invoking Foucault, suggests that we can formulate a new biopolitics based on care, in adjusting individualist ego psychology to one expressing our shared entanglement with others. Similarly, in the following section, I want to outline how the stakes of the rehabilitation enterprise are open to analysis through the psychoanalysis of desire.

Here, allow me to recapitulate our progress to this point. I began with a basic sketch of Freud's psychoanalysis. I suggested some adjustment of Freud's work was in order. This was in line with the problem of developmentalism. This means moving from a critique of psychoanalysis to a productive theory of object relations, treating the clinical space as a system of desiring production, producing, and circulating social roles. While we can and must legitimately critique Freud's model of desire and development, *we can find other lines of flight within.*

## Life, Death, and Desire: Toward a Social Psychoanalysis of Clinical Forces

The reader has almost certainly noted that this is a theoretical paper, written by a social theorist. I am not a trained rehabilitation practitioner. However, as a subject of rehabilitation, a disabled social theorist, and a sociologist who has participated in empirical research into rehabilitation practice, I use this section to document the empirical possibilities stemming from a clinical psychoanalysis. Here I look to three possibilities: (1) individualism in rehabilitation practices; (2) life with disability; and (3) the emergence and management of death in both literal and symbolic manifestations. In each of these facets, the psychoanalytic approach is *critical:* questioning clinical categories, attending to power relations, and thinking in non-positivist ways.

A key space of inquiry in critical rehabilitation science has been the exploration of patient and practitioner



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subjectivity. How does the rehabilitation clinic shape the contours of being a patient, a parent, or an appropriately professional practitioner? How does power inform the options being given, and those denied to a clinical subject, as in 'person-centered care'?

A psychoanalysis of clinical desire is deeply interested in how finite actors are individuated. Person-centered care does not, I argue, map the existing desires of existing subjects. It shapes them. In Parsonian terminology, we can argue that patient and practitioner social roles are *moral*—reflecting a set of ethical interrelationships to health, wellness, capacities for action, and obligation to other social-role types in the clinical action system. When we express desire, we do so in and through these interrelationships. To be centered as a person, then, is to become so amidst a social system. Object-choice extends to the very real objectives to be met in the rehabilitation clinic.

To speak of object-choice and social roles is necessarily abstract, but their implications are decidedly important for business-as-usual clinical practices and their critique. Gibson et al[22] have explored the "micropolitics of tinkering," and the constitution of clinical subjects' person-centered care. To place a subject at the center of care does not take place in a motivational vacuum. These clinical entablements are made starkly clear in the case of 'benevolent manipulation.' Person-centered care, Gibson et al found, is a negotiation, a politics of the possible, achievable, and desirable at work. Patients must be compliant, "but not too motivated," as one of their respondents put it. They must be put at the center of care, and yet managed under the direction of a practitioner versed in current, evidence-based practices. Expertise remains integral to the process. Practitioners, too, become morally invested in the outcome of patient-centered care. "Care encounters thus materialize the subjectivities of all involved in ways that might be intended or not, welcomed or not. Said differently, [patient centered care] and other practices shape the personhood of all persons in the encounter, not only the 'patient'."[22] Patient and practitioner are emergent social roles, with prescribed social scripts, motivations, and goals—and in practice, always subject to mutual adjustment.

## SOCIOLOGY OF CLINICAL MOTIVATIONS AND CARE

Here I would argue that a sociology of clinical motivations is a clear candidate for psychoanalysis. The investment of the patient and practitioner in the practices of the other is as stark an example of transference as can be imagined, whereby the clinical encounter becomes a space of object choice, with desires mapped onto the social role of the other. This is not merely a biproduct of therapy—it is its *basis*. Transference is ultimately the process of affect mobilization, bodily entanglement, and conscious and unconscious desires. It cannot be fully 'tamed,' much as we would like to do so (think, Freud's horse-and-rider metaphor). Understanding the complexities of object choice requires an approach that sees past each agent as an isolated set of preferences. One must be sensitive to the process of individuation.

The problem of developmentalism is also a matter of life and death—when we interrogate the kinds of lives that are mapped out in the clinical space, and the way lives *will not* unfold. Psychoanalyst Adam Phillips treats "lives not lived" as a crucial space of our human being.[23] The desires we express in the options we did not choose, or *could not choose*, can often tell us as much about our desires as the paths we do take. As part of a 3-year study on 2 outpatient Muscular Dystrophy



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clinics,[24,25] I found the problem of developmentalism manifest in parent attitudes toward lives that their children would not lead. The clinics served outpatient populations—children and their families—who would attend sessions every 4 to 6 months, to monitor the progression of the condition, most often Duchenne Muscular Dystrophy (hereafter DMD). Youth with DMD would lead different lives than their peers, with most living into their 30s. Billy (a pseudonym), age 4 when he was seen by one of the clinics, came in with both his parents. His diagnosis was recent, and the somber energy in the examination room expressed as much. Billy's parents were clearly still in mourning, stating at one point, he had been "robbed of a childhood." And in a way, he had been—insofar as his parents had been given, like most, a belief that their child would develop 'normally.' Billy would not. He would most likely live into adulthood, but not through the pre-ordained path. In this visit, and I presume others after the conclusion of the study, the clinicians spent a great deal of mental and physical energy attempting to adjust the framework for Billy's life. In effect, each member of the clinical team was addressing object-choice, and the problem of developmentalism reared its head. Like so many others, Billy's parents had expected their child's life would take a path that did not include DMD. Their sombre mood, and reluctance to interact with clinicians arose from this fact. The clinicians, too, aimed at the transference of psychic energies. Their goal: shift energy from the life Billy would not live to the one he could. In this case, a typical childhood was not an illusion; it took up a great deal of psychic space, while his parents were in mourning. The fantasy of a typical childhood is just as real as the fantasy of patient autonomy. We will never actually live through them, but we can mourn their loss all the same. The charge of critical psycho-social care is to understand and accept this process.

Finally, the question of death. Here we must engage death not solely as an event ending a life to be rationalized at the levels of the id and superego. Death is also *assembled* and *anticipated* in concert. It, too, can be explored at the level of a life not lived. Given the atypical lifespans of young people with DMD, death and dying were on the tips of the tongues of parents, children, and practitioners in the observed clinics.[26] This Freud calls the "psychopathology of everyday life." These behaviors are determined by the same libidinal structures as any other act. In an affirmative, disability studies-inspired rewording, we might indicate that 'abnormal' behavior is merely a mis-labeling of the tendencies we all have in routine social interaction. Death was made present in the minor social cues through which it was repressed from conversation. Here, we return to the same life and death instincts Freud maps in *Beyond the Pleasure Principle,*[9] albeit at the level of clinical practice rather than collective instincts.

Death was also *absent* in the clinical space. Nobody died while we observed the clinic, and the young men there would typically live significantly longer than the age-cut-off designated at the children's hospital. Clinical observation showed that the 'doom and gloom' of DMD, however, was manifest in fidgeting, welled-up tears, and awkward silences whenever it could be, but was not invoked. Comparing data in Canada and the UK, we found many of the problems faced by patients involved the *in*ability to have direct discussions about the time they had to live. As one respondent in the UK put it, "If a doctor can't talk about it and you don't have a close relationship with your parents when it comes to these types of issues, then who you gonna call?"[27] What typically would be called a 'difficult discussion' among parents, patients, and practitioners, in the psycho-social aspects of muscular dystrophy care, is in fact a conversation that doesn't happen often enough. Of course, no parent *wants* to address the



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death of their child in a routine way. But this is not the point. Questions of mortality and end-of-life planning are deep existential questions—ones that avoid narrow and individualizing practices of 'evidence-based' or 'patient-specific' care. They are critical questions—in each sense of Gibson's framing. They question the taken-for-granted process of care.

We lack a checklist of best practices for addressing a death. It is a question of power, insofar as clinical energies and resources are mobilized to plan for a decent end to life (or not). This is done at the supra-individual level. Finally, they show us the existential vacuum left to us by positivism's underlying skepticism. Critical tools are required.

## Conclusion: Rehabilitation and Desire

I have argued that psychoanalysis has something to learn from the critical rehabilitation sciences, and vice versa. I suggested that both a radical Deleuzian and conservative Parsonian re-reading of Freud allowed us to account for the collective energies at work in psychic life, without losing the social structures at work in rehabilitation practice, or any other form of oriented social action.

Their common root: the mobilizing power of desire. We moved from an individualizing model of psychosocial development to a critical, historical, and social understanding of desiring forces. To see the subjects of desire as *established*, rather than *given*, is one manner of attending to the problems of normative development. The problem of developmentalism is manifest, too, in work that fails to account for forms of identity and marginalization, occluded in purportedly 'universal' trajectories of human development. This difficulty, I maintain, is found in the psychoanalytic writing examined in section one. Looking to feminist critiques of psychoanalysis, I hoped to make space for a wider spectrum of humanity than Freud did. I argued that the fantasies of liberal individualism and of patient autonomy are similarly imagined. They might not be accurate, but as fantasies they are still real, and subject to psychoanalytic exploration. Finally, although this is an article about theory, I reflected on what all this might actually mean for those doing critical work in the rehabilitation sciences. I end with two possible objections to what I have written.

First, *psychoanalysts* might say that I have watered down Freud's concepts, and divorced his work from the biological and clinical base through which desiring forces emerge and are explored. This critique is fair; I have. I would reply that Freud's frequent refrain is that clinical evidence substantiated all of his claims. I simply ask that we look to a new kind of clinic. If the above theory lets us explore clinical energies in new, critical ways, then that is good enough for me. Again, my focus is on meaning, not statistical verification.

Second, *sociologists* and those in *disability studies* might argue that I have adopted an approach that is rotten to the core. Try as I might to rehabilitate the work of Freud, he cannot fully address the problems of capitalism, inequality, and normalization. I agree that Freud's work has a great many problems—some of which I highlighted in the section on feminist critiques above. (Critical work, as Gibson makes clear, is an ongoing project.) To this objection to my approach, my reply is "yes, but then what?" If we take the problems of Freud's work as problems *to be solved*, then I believe we are justified in reading it. I do not like Freud's heteronormativity any more than the critics do. I think we can address it at the theoretical level, and inform critical practice aimed to combat its thoughtless reproduction. This should be justification enough.



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To treat the clinical space as a libidinal space is, I would argue, a critical and political act. It allows us new and novel ways to explore the motivations of patients and practitioners in the rehabilitation clinic. It lets us engage with the mobilizing power of desire and imagine our shared meaningful connections in ways passed over by a naïve and de-politicizing individualism.

Finally, I believe this psychoanalytic perspective is a mechanism through which to fold a critical social-science approach to inequity into the evaluation and reformulation of routine clinical life. Although I have only briefly sketched what that evaluation and reformulation might look like—looking at how death and desire flow through the clinical space—it is a start. I suggest that we can wrench some concepts from Freud and explore the rehabilitation clinic as a space of desire—whether he would like it or not. Here, future critical, clinical research is needed. I hope to have provided some tools toward that task.

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**Thomas Abrams, PhD** is an Assistant Professor of Sociology at Queen's University (Kingston, Ontario, Canada), where he teaches sociological theory and the sociology of health, illness, and disability. His work employs social theory and philosophy to explore the experience of disability as an institutional outcome. This process began in his dissertation work, using phenomenology to make sense of his personal experience of muscular dystrophy. This has since led to a research program in the sociology of rehabilitation. Dr. Abrams continues to use social theory and philosophy to bring an interdisciplinary, disability studies perspective to critical work on health, illness, and rehabilitation.



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