Upping the Anti: Psychiatrization, Survival, and the Politics of Alterity

by

Eugenia Kin-Kwun Tsao

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Graduate Department of Anthropology
University of Toronto

© Copyright by Eugenia Kin-Kwun Tsao, 2013
ABSTRACT

Based on archival research (1970s to 1990s), media analysis (January 2006 through January 2011), and ethnographic fieldwork (August 2009 through September 2010) conducted in and around the Canadian city of Toronto, this dissertation explores a jarring disconnect between mainstream representations of psychiatric illness and intervention, and psychiatric survivors’ representations of the same experiences. Whereas the news media consistently portray the brains and bodies of psychiatrized people as existential threats to the national body politic, those with firsthand knowledge of the pathway from medicalization to medication frequently advance very different claims: that it is psychopharmaceutical compounds and not “mental illnesses” that usurp and assail people’s rational faculties and derail cherished aspirations, and that it is dissent rather than compliance that confers health. Due to both the extensive credibility that psychiatry enjoys throughout civil society and pharmaceutical firms’ enthusiasm for marketing not just drugs but diseases, individuals who are averse to medical intervention must contend with the twin stigmas of diagnosis and distrust; fully aware that they are viewed as unruly and inauthentic by both the public and their own families, they learn to dissemble and prevaricate about their lives in acts of protective self-silencing. Because forcible detention is always a latent threat, there is little manoeuvring room for people who wish to recover from lives of hardship but emphatically reject the equation of recovery with biological normalization, and of madness with illness. Over the past four decades, psychiatrized individuals have counterbalanced their marginality by mobilizing under collective identifiers like “anti-psychiatry,” “psychiatric inmates’ liberation,” “the psychiatric survivor movement,” and “mad pride,” and militating against prejudicial attitudes toward behavioural deviance. While these efforts have born some fruit, the overwhelming predominance of white voices in all of these communities has led to the trivialization or erasure of other genres of injustice, an outcome that has not gone unnoticed by participants who are both racialized and psychiatrized. The dissertation thus concludes by considering how collective identity labels can be just as alienating and silencing as psychiatric labels to those who transgress received criteria for virtuous conduct that mask, and thereby reinforce, hegemonic social norms.
Acknowledgements

Graduate school would have been unendurable without the aid, encouragement, and companionship of a great many people. If your name does not appear in these paragraphs, please be assured that it is an oversight and not a slight.

I am indebted, first and foremost, to the participants in this study, who invited me into their lives with limitless patience and warmth, thereby making everything in the following pages possible. It is to them—and to all psychiatrized people, past and present—that this dissertation is dedicated. I particularly thank my friends whom I have pseudonymously referred to as Ana, Cassidy, Helen, Ivy, MacDaniel, Olivia, Richter, Ryan, and Yashar for cheerfully tolerating my naïve questions and urging me to unpack my many preconceived notions. In addition, my unreserved gratitude goes to Gary Novak and Robert Roth for entrusting irreplaceable historical texts into my care, without which my third chapter could not have been written. For similar reasons, I thank everyone at the Psychiatric Survivor Archives of Toronto for their diligent stewardship of the city’s extensive psychiatric survivor historiography.

To my supervisors, Bonnie McElhinny and Holly Wardlow, without whose wisdom and guidance this dissertation could never have come to fruition, I offer my humblest thanks. Every step in my postgraduate journey has been made possible by their generosity, and every page of this document has been improved by their input. I could not have asked for a better pair of advisors. I am also indebted to my external and internal examiners, Andrew Scull and Paul Antze, who supplied me with invaluable feedback that enhanced my understanding of many vital issues; Sandra Bamford, who taught me the art of ethnography during my Master’s degree; Andrea Muehlebach, who served on my proposal defence committee; and Michael Lambek, whose Centre for Ethics seminar on continuous and discontinuous persons helped me to unpick some of the more intractable epistemological problems that arose during my fieldwork.

For teaching classes that informed my work in innumerable ways, I gratefully acknowledge Joshua Barker, Janice Boddy, Hilary Cunningham, Naisargi Dave, Marcel Danesi, Valentina Napolitano, Todd Sanders, Mark Solovey, Jesook Song, and the late Krystyna Sieciechowicz, in addition to Holly, Bonnie, and Sandra. In fact, all of the instructors and teaching assistants who made my postsecondary education possible deserve rich and heartfelt thanks: every one of them, without exception, has contributed something to this journey. I am especially thankful to Marnie Bjornson, Conor Burns, and Susanne Miskimmin for being so generous with their time and advice during my final undergraduate year, and to Leslie Jermyn for teaching the class that first drew me into anthropology. I must also thank my own students, who have consistently provided me with much food for thought and even more rollicking fun.

I have spent many afternoons dashing into and out of the offices of Josie Alaimo, Kristy Bard, Roger Bulgin, Annette Chan, Sophia Cottrell, Natalia Krencil, Kai-Lii Veer, and Diane Yeager with hastily completed forms, thick stacks of essays, broken keys, and one Kafkaesque request after another. They have been the administrative pillars of this department, and I thank them for the forbearance and good humour that have made my time here so smooth and enjoyable. I will miss our mirthful photocopier room conversations.
I am a beneficiary of a long history of student activism at this university, and I thank all those whose efforts made it possible for me to enjoy such things as health insurance and guaranteed funding. Particular appreciations are due to Rachel Aleks, Ann Cope, Paul Gorczynski, Caitlin Henry, Leslie Jermyn, Katie Mazer, James Nugent, Robert Ramsay, Sara Suliman, Chantal Sundaram, Shiraz Vally, Patrick Vitale, and numerous others whom I met and worked with at CUPE 3902, not only for their gracious support of my artistic pretensions, but also for their tireless contributions to social justice and equity in higher education.

Many friends and colleagues deserve credit for keeping me on an even keel during the dissertating process. Kori Allan, Lisa Davidson, Chantelle Falconer, Sharon Kelly, Lucinda Li, Krista Maxwell, Anna Polonyi, Diana Tseng, Lily Yiu, Asli Zengin, and the incomparable Call for Capers Crew—Laura Bolt, Rastko Cvekić, Ryan Janzen, Daniella Jofré, Dean Langan—were saucy and hilarious companions in dining and commiseration when such things mattered most. Alyson Stone, equally saucy and hilarious, was a wellspring of anthropological insight and a resourceful partner in campus activism. My friends at the Coalition Against Psychiatric Assault, including but not limited to Simon Adam, Rebecca Ballen, Bonnie Burstow, Shaindl Diamond, Coreen Gilligan, and Don Weitz, were exemplars of political courage and underdog indefatigability. Countless others were founts of thoughtful camaraderie and refreshing conversation at precisely the right moments, most notably Karen Angus, Hamna Anwar, Josephine Eric, Martha Fanjoy, Greg Gunton, Aaron Kappeler, Kris Meen, Hollis Moore, Jacob Nerenberg, Behzad Sarmadi, Laura Sikstrom, Peter Skrivanic, Eloisa Stella, Jessica Taylor, Zoë Wool, Sunyoung Yang, and the tireless Blackandred of MostlyWater.org, as well as Danielle MacDonald, Catherine Merritt, Carmen Nave, Lauren Norman, Jim Orwig, Margaret Procter, Kathleen Rice, Louise Tam, and Mike White. Jennifer Lem and Carina Chu were an uplifting presence during my undergraduate sojourn. Jordan Pelc was fathomlessly supportive during the early existential challenges. You are all outstanding human beings whom I am privileged to have known.

Jeffrey St. Clair and the late Alexander Cockburn facilitated some of my most fertile research leads by generously allotting me space in the Counterpunch print edition. Wherever you are, Alex, my eternal thanks to you for the kind words, the books, and everything betwixt and between.

My greatest debt is of course to my family—my brilliant sister, Ami, and my redoubtable mother, Jennivine—whose love and patience have been bottomless. On a daily basis, they show me what strength and determination really are; suffice it to say, my appreciation and admiration are without limit.

Special recognition is also due to my computer, which in ten years has never once let me down.

This project was funded by a Vonda McCrae Clarke Memorial Ontario Graduate Scholarship in Anthropology (OGS, 2010-2011) and a Social Sciences and Humanities Research Council Canada Graduate Scholarship (SSHRC-CGS-D, 2007-2010). Any errors of fact, judgement, or reasoning that appear in this dissertation are, of course, entirely my own.
Table of Contents

Chapter 1. Introduction: Scope, Stakes, Research Questions 1
1. “And, So, Now, I’ve Taken My Brain Back”
2. The Medicalized Imagination
   2.1. Pathologization as Zeitgeist
   2.2. Anthropologies of Psychiatry: Themes, Trends, and Trajectories
   2.3. Instrumentalizing Identities: Social Movements and Their Analysts
3. Organization of the Thesis
   3.1. Outline of Chapters
   3.2. Regarding the Author’s Positionality
   3.3. Regarding Terminology
   3.4. Transcription Conventions

Chapter 2. Setting the Scene: Methodologies and Modes of Inquiry 30
1. Locating the Field
   1.1. Geographic/Biographic Boundaries
   1.2. Mental Healthcare in Ontario: Infrastructure and Oversight
2. The Study Population
   2.1. Folie à Deux: An Anti-Psychiatry Reading Group
   2.2. Acceptance: A Family Support Group
   2.3. Unhinged: An Arts Therapy and Peer Support Group
3. On the Author’s Access to Primary Historical Sources
4. Ethnographer or Voyeur?

Chapter 3. Changing Minds: Psychiatry and Anti-Psychiatry in Historical Context 49
1. “She’s Not the End-All, Be-All of this Thing”
2. From Manacles to Manuals: Defining Objects
   2.1. Populating the Asylum: The 17th and 18th Centuries
   2.2. Undesirables at Home and Abroad: The 19th and Early 20th Centuries
   2.3. Specificity and its Uses: The Mid- to Late 20th Century
   2.4. The Pursuit of Happiness
3. The Fish and the Phoenix: Resisting Objectification
   3.1. Dissidence in Motion
   3.2. Ends and Means I: Resistance in an Era of Resistance
      3.3.1. Medical Consumerism Gains Traction
      3.3.2. A Penny For Your Thoughts: Professionalization and the Co-optation Debates
4. When Counterarguments Collide

Chapter 4. “It Strikes Anyone”: Medical Journalism and the Construction of Crisis 126
1. Sounding the Alarm
   1.1. The Commodification of Mental Health
   1.2. Public Attitudes and the News Media
   1.3. A Reminder
2. The Corpus: Size, Scope, and Rationale
   2.1. Data Collection
   2.2. Like the Air We Breathe: Key Trends in News Coverage, 2006-2011
3. The Thief: A Lesson in Civics
   3.1. “How a Typical Teenager was Stolen Away”
   3.2. “I Know Now That It Was a Monster That Controlled Her”
      3.2.1. Know Your Enemy
      3.2.2. They Walk Among Us
3.2.3. It Takes a Village
3.3. Rehabilitating Desire
4. Chasing Ghosts

Chapter 5. Pedagogy of the Depressed: Pain, Psychiatrization, and Prevarication 166
1. On Showing and Telling
   1.1. “And Every Single Time He’d Twist My Words”
   1.2. Contested Etiologies
2. Yet There Is Method In It: Madness and Its Logics
   2.1. Bite Your Tongue: Putting Others’ Feelings Ahead of One’s Own
   2.2. Heroes and Outlaws: Developing Alternative Competencies
3. Iatrogenesis: Derailed Identities, Disarrayed Bodies
   3.1. Losing One’s Self to Psychiatry
      3.1.1. “Like Searching for Darkness with a Flashlight”
      3.1.2. First, Do No Harm?
   3.2. The Wisdom of Silence
4. Whither “Recovery”?

Chapter 6. “It’s Not (Just) Me”: Transgressive Recoveries and the Politics of Compliance 210
1. The Either-Or Fallacy
2. The Canons of Recovery
   2.1. Unpackaging Insight and Compliance
   2.2. Diminishing Returns: The Costs and Benefits of Non-Compliance
3. Being a Good Patient vs. Getting Better
   3.1. “How Can You Not Have Fear In Your Life?”
   3.2. “What We See, Nobody Else Does”
4. On Other Forms of Insight
   4.1. “You Have to be Brought to the Depths of Hell”
   4.2. When Compliance is Incompatible with Comprehension

Chapter 7. The Tyranny of Categories: Sanism and Racism in Theory and Practice 270
1. “These People are Crazy”
2. Madness, Sanity, and the Problem of Volition
   2.1. Getting Mad: Anti-Psychiatric Politics in the Mad Pride Era
   2.2. The SSRI Revelations: From Missing Link to Groupthink
   2.3. Going Mad: Alteration or Amplification?
3. On the Accumulation of Tiny Indignities
   3.1. The Eye of the Storm: “Hey Princess, This Isn’t Dinner Theatre”
   3.2. The Storm: “You’re Seeing Things that Aren’t There”
   3.3. The Fallout: “Welcome to the Club”
4. Other Kinds of Chains

Chapter 8. Rethinking Normal: Conclusions and Directions for Future Inquiry 331

Appendix I. Map of Municipalities in the Greater Toronto Area (GTA) 337
Appendix II. Archival Images and Illustrations 338
Appendix III. Annotated Glossary of Abbreviations 350
Works Cited 358
### List of Tables

| Table 4.1   | Origins, Ownership, and Availability of Items in a News Corpus, 2006-2011 | 145 |
| Table 4.2   | Changeling Metaphor, Premise I. “‘Mental illness’ is a malicious entity that acts independently of its host.” | 150 |
| Table 4.3   | Changeling Metaphor, Premise II. “The ‘mentally ill’ are categorically different and cannot speak for themselves.” | 152 |
| Table 4.4   | Changeling Metaphor, Premise III. “As a community, we have to detect and eradicate ‘mental illness.’” | 156 |
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>“Tone-Deaf to the Screams / Of the Instruments / Upon Which They Play.”</td>
<td>338</td>
</tr>
<tr>
<td>3.2</td>
<td>“All the Fits that’s News to Print.”</td>
<td>338</td>
</tr>
<tr>
<td>3.3</td>
<td>“Legislation &amp; Litigation.”</td>
<td>339</td>
</tr>
<tr>
<td>3.4</td>
<td>“You Deprive Us of Love and Give Us Candy and Bingo.”</td>
<td>339</td>
</tr>
<tr>
<td>3.5</td>
<td>“Mad Librarian.”</td>
<td>340</td>
</tr>
<tr>
<td>3.6</td>
<td>Rising From the Ashes.</td>
<td>340</td>
</tr>
<tr>
<td>3.7</td>
<td>“Phoenix Pharmacy.”</td>
<td>341</td>
</tr>
<tr>
<td>3.8</td>
<td>“Giving Them the Bird.”</td>
<td>341</td>
</tr>
<tr>
<td>3.9</td>
<td>Vegetables.</td>
<td>341</td>
</tr>
<tr>
<td>3.10</td>
<td>“How I Got Myself Back.”</td>
<td>342</td>
</tr>
<tr>
<td>3.11</td>
<td>“Sane Response to an Insane World.”</td>
<td>342</td>
</tr>
<tr>
<td>3.12</td>
<td>“They Say We Are Crazy, They Say We’re Insane / But We Don’t Make Atom Bombs or Acid Rain.”</td>
<td>343</td>
</tr>
<tr>
<td>3.13</td>
<td><em>Madness Network News</em>’s Coverage of the 1982 Toronto Conference.</td>
<td>343</td>
</tr>
<tr>
<td>3.14</td>
<td>“Declaration of Principles.”</td>
<td>344</td>
</tr>
<tr>
<td>3.15</td>
<td>“We’ve Always Been Thrown a Few Crumbs Along With Our Thorazine.”</td>
<td>344</td>
</tr>
<tr>
<td>3.16</td>
<td>“We Believe that Psychiatry Cannot Be Reformed but Must be Abolished.”</td>
<td>345</td>
</tr>
<tr>
<td>3.17</td>
<td>“Farewell.”</td>
<td>345</td>
</tr>
<tr>
<td>4.1</td>
<td>Moral Representations of “Mental Illness” in the News Media, 2006-2011</td>
<td>140</td>
</tr>
<tr>
<td>4.2</td>
<td>Systematic Silencing of Psychiatrized People in the News Media, 2006-2011</td>
<td>143</td>
</tr>
<tr>
<td>4.3</td>
<td>“Researchers’ Guess.”</td>
<td>346</td>
</tr>
<tr>
<td>4.4</td>
<td>“There’s a Really Fundamental Difference in the Way They’re Perceiving Things.”</td>
<td>346</td>
</tr>
<tr>
<td>4.5</td>
<td>“Illness Kills, Not Individual.”</td>
<td>346</td>
</tr>
<tr>
<td>6.1</td>
<td>“Come Back Here! You Can’t Fly. You’re Just a Caterpillar!”</td>
<td>347</td>
</tr>
<tr>
<td>6.2</td>
<td>“Common Myths.”</td>
<td>347</td>
</tr>
<tr>
<td>6.3</td>
<td>The Enemy?</td>
<td>348</td>
</tr>
<tr>
<td>6.4</td>
<td>“Look At This Stuff, Look.”</td>
<td>348</td>
</tr>
<tr>
<td>7.1</td>
<td>“Next Month in Toronto, He’s Scheduled to Talk.”</td>
<td>349</td>
</tr>
<tr>
<td>8.1</td>
<td>“Maybe It’s A Hospital.”</td>
<td>349</td>
</tr>
</tbody>
</table>
List of Appendices

Appendix I. Map of Municipalities in the Greater Toronto Area (GTA) 337
Appendix II. Archival Images and Illustrations 338
Appendix III. Annotated Glossary of Abbreviations 350
Chapter 1
Introduction: Scope, Stakes, Research Questions

1. “And, So, Now, I’ve Taken My Brain Back.”

I couldn’t stop myself from cringing when Pascal began tearing up his diaries, the grin on his face as joyous as any I had ever seen. His friends cheered with each fistful of paper he seized, the perforated pages crackling as they peeled away from their spiral bindings, crunching as he balled them up and pitched them across the room. When he was done, he had destroyed a total of six notebooks, each of which had been filled with poems, song lyrics, and other writings that he had accumulated over three years. As his friends and fellow psychiatric survivors Ashley, Olivia, Fleming, and Richter milled around him, offering congratulations, I hung back, perplexed. I had arrived at Pascal’s apartment shortly before these events, having been told to expect “festivities” marking the first anniversary of his discontinuation of SSRI antidepressants. And indeed, there did seem to be something festive about his actions and how his peers were responding to them. Clearly, this was meant to be a celebration, but what I did not yet understand was: of what?

Someone activated Pascal’s stereo system and a pounding bass line filled the room. He and the others were now all heaped on or around a giant beanbag chair, chatting. Ashley offered me a beverage, and then, perhaps picking up on my bemusement, she put her hand on my shoulder and gently asked, “You don’t get it?” I didn’t, and said so. She leaned in closer, as if to spare me the embarrassment of having the events explained within earshot of the others.

“He was on drugs for three whole years,” she pointed out. “He’s getting rid of the stuff he wrote when he wasn’t himself.”

I nodded, intrigued by her claim that Pascal’s medications had somehow alienated him from his authentic self. Satisfied that I understood, she rejoined the group and, in short order, I also tried to find a spot near the crowded beanbag.

Later that evening, as we deposited styrofoam take-out boxes and crumpled wads of notebook paper in a garbage bag, I asked Pascal why he had destroyed three years’ worth of personal writings. His answer corroborated Ashley’s analysis, but also mobilized a complex of possession metaphors that I had, until then, encountered only in reference to what psychiatric illnesses—not psychiatric drugs—do to their victims. During his time on SSRIs, “it was like I went away, and some other guy took over,” he explained. “And, so, now, I’ve taken my brain back. So, whoever that guy was and whatever he wanted has nothing to do with me,” he said flatly, tightly knotting the neck of the garbage bag. “He doesn’t live here anymore.”
This is not, fundamentally, an ethnography about either mental illness or psychiatry. It is an ethnography about why people come to spurn mental illness labels and resist psychiatric interventions, and what modes of reasoning and collective action they deploy in so doing. More specifically, it is an ethnography about the unique ethical and existential dilemmas that resisters of mainstream biopsychiatry face as a result of a jarring disconnect between their own experiences with “illness” and “treatment,” and their surrounding culture’s representations of the same experiences. By drawing from fourteen months of fieldwork in the Greater Toronto Area (August 2009 through September 2010) and five years’ worth of news reportage (January 2006 through January 2011), I argue that the mass media’s consistent portrayal of psychiatrized bodies and brains as threats to the national body politic serves to delegitimize the radically different narratives advanced by the owners of those bodies and brains. Contrary to popular stereotypes, individuals who have traversed the pathway from medicalization to medication routinely assert that it is psychopharmaceutical compounds and not mental illnesses that impair rational faculties, displace authentic opinions, and derail cherished aspirations; and that it is dissent from, rather than compliance with, medical advice that confers mental health. Due to psychiatry’s extensive credibility throughout civil society and pharmaceutical firms’ enthusiasm for marketing not just drugs but diseases, such individuals must contend with the twin stigmata of diagnosis and distrust; fully aware that they are viewed as unruly and inauthentic by both the public and their own families, psychiatric survivors learn to dissemble and prevaricate about their lives in acts of protective self-silencing. Because forcible detention is always a latent threat, there is little manoeuvring room for people who wish to recover from lives of hardship but who emphatically reject the equation of recovery with biological normalization, and of madness with illness.

In 2006, psychiatrist Michael Corry asked, “Anti-psychiatry movements abound, yet none exist in other branches of medicine. Why?” He suggested that psychiatrists alone were failing to meet their patients’ needs, while other practitioners of medical subspecialties were “all accomplishing their primary task, that of delivering the best possible service” (quoted in Maddock and Maddock 2006: 146). Although Corry rightly acknowledged that for many patients, “little to no healing occurs during psychiatric treatment, merely containment by ‘medication,’ fostering in sufferers a climate of hopelessness” and leading to an understandable mistrust of psychiatry (2006: 146), his answer overlooked a key dimension of the issue: why, when, where, and how have the grievances of individual patients led to the rise of international
anti-psychiatry movements with their own newspapers, iconographies, jargons, folk heroes, and received wisdoms? How do psychiatric survivors find broader forms of ratification for their dissent and convene in pursuit of change? By considering the heterogeneous avenues through which ideological solidarity was maintained, tested, contested, and fractured within three organizations that I studied during fieldwork—a suburban anti-psychiatry reading group, a downtown anti-psychiatry/arts therapy group for (mainly) psychiatric survivors, and a peer support group for family members of psychiatric patients—this dissertation offers a clearer window into the phenomenon that Corry identifies. It suggests, furthermore, that the task of collectively mobilizing against psychiatric epistemologies is regularly frustrated by participants’ conflicting conceptions of psychiatrization, survival, and social justice. In short, having to contest psychiatry in a principled and consistent manner brings some people together with distinctive warmth and intimacy, but it tears others apart with breathtaking acrimony.

How are these countervailing tendencies sustained in spite of each other? This thesis treats both as inevitable outgrowths of the fraught relationship between “psychiatry,” treated here not as a mere medical discipline but a web of cultural and institutional productions that circulate through everyday life with systematic implications (Martin 2007), and “anti-psychiatry,” conceived in these pages not as a monolithic political ideology but, rather, a rich tapestry of interconnected projects to which people of diverse backgrounds contribute in an effort to give expression to grievances, objections, and resentments they have developed toward psychiatric discourses and practices. My aim here is twofold. While the universalizing imperatives of the Diagnostic and Statistical Manual of Mental Disorders have been subjected to increased scrutiny in recent times, wide-ranging discourses continue to portray the “mentally ill” as uniquely deficient and unable to speak credibly on their own behalves, particularly when they are rejecting diagnoses (“lack of insight”) and resisting treatment (“non-compliance”). My primary objective is to destabilize the narrative assumptions that underlie such portrayals, and, in so doing, to problematize binary conceptions of mental health/illness. By evaluating the knowledge claims of individuals whose life stories are anchored in ongoing resistance to psychiatrization, I will show that their aspirations toward “mental health” are inseparable from their aspirations toward physical safety, privacy, financial solvency, creative agency, meaningful sociality, freedom of information, and freedom of choice. The primacy of DSM terminologies and pharmaceutical technologies in the rehabilitative literature diverts attention from the polysemous nature of wellness, and silences people whose refusals to distinguish between their bodies, psyches, and lives do not jibe with perspectives backed by medical authority.
My secondary objective is to consider the ways in which counterhegemonic initiatives both facilitate and thwart psychiatric survivor activists’ ambitions of avoiding stigma, mitigating humiliation, and achieving dignity. Why might arguments that are designed to be empowering or educative end up being, in practice, alienating to some constituencies? How do people legitimize their claim to survivorship—that is, to the claim that they wield “the voice of experience” (Gabriel 2004: 168)—in the face of others’ allegations that their suffering has been somehow inadequate or inauthentic, or that their ideological commitments are somehow impure? I contend with these questions by exploring how people learn to inhabit the countercultural identities embodied in terms like “anti-psychiatry,” “Mad,” “psychiatric inmate,” and “psychiatric survivor” when negotiating the confluences of privilege and marginality that inhere in any social network; in so doing, I reflect on what it means when androcentric, classist, and ethnocentric values afflict the moral worldviews of people striving for social justice. My findings do not align neatly with canonical models in social movement research whereby “collective identities” unify the agendas of disparate actors, “providing structure, a basis for commitment, and guidelines for individualized participation” (Haenfler 2005: 785). In particular, as will be seen, the overwhelming predominance of white voices in Western anti-psychiatry has led to the trivialization of other genres of injustice within psychiatric survivor circles, an outcome that has not gone unnoticed by participants who are both racialized and psychiatrized. The dissertation thus concludes by considering how “collective identity” labels can be just as silencing as psychiatric labels to those who transgress received criteria for virtuous conduct that mask, and thereby reinforce, hegemonic social norms.

2. The Medicalized Imagination: Locating the Problem

2.1 Pathologization as Zeitgeist
The bus was late, I was not dressed for the chilly weather, and the transit shelter in which I was standing provided little insulation. As I stared out from the glass enclosure, shivering, impatient, and annoyed with myself for not wearing a warmer coat, a woman crossed the street and positioned herself next to me. She appeared to be white and in her late thirties or early forties.

1 As will be discussed in chapters 3 and 7, the subjective character of the “psychiatric survivor” identity, which is riveted on questions of firsthand experience, is a both a key feature of participants’ political strategies and a major source of tension between those who do not see all forms of trauma as equal.
“I see the bus coming,” she declared. I looked and saw nothing, just the usual trickle of sedans and minivans that made up weekend morning traffic in the suburbs. She took a step closer to me, and tried again: “Coming down the hill. Don’t you see it?”


“Where are you from?” she asked.

“Thornhill,” I said, referring to the very community in which we were standing in order to nip potential questions about my ancestry in the bud. As a Canadian-born person of visibly East Asian descent, this was a question that strangers on the street posed to me on a regular basis. I was not in the mood for conversation, moreover, and so my replies were curt, designed to discourage further inquiries.

“I’m from Canada,” she announced with a smirk, then added, “Starbucks’ coffee is too expensive. McDonald’s is cheaper. Do you want a copy of this?” She gestured at thin air.

“No, thank you.” I shifted uncomfortably and glanced down the street, hoping to catch sight of the bus. Cars rushed by.

“I know you’re cold,” she chuckled, “but I’m not.” Another smirk, and then another sudden topic shift: “The moon festival is on Wednesday. It’s very important to the Chinese. I have a cousin in Hong Kong, you know. The bus is coming—look, look.”

I looked. It wasn’t. So I turned back to the woman, but she seemed to have lost interest in me. She was singing softly to herself, and pressing a clenched fist into the wall of the bus shelter. I studied her; she wore a pashmina shawl, ankle boots, a long woollen coat, and eyeglasses whose arms bore the emblem of an Italian fashion label. There was nothing about her attire or carriage that I would have found unsettling had I glimpsed her from a distance. But our exchange struck me as somehow a bit off, out of sync with the rhythms of common courtesy, and a lifetime of habit and enculturation came together to direct my next action: I walked, slowly, out of the glass enclosure, and picked a spot about five metres away to continue waiting.

The bus pulled up not long afterward, and I let the woman enter first. She selected a seat near the front, I made my way to the back, and we both sat in silence for the duration of the journey. As we travelled northward, I began to feel guilty about what I had done. The woman had done nothing whatsoever to harm or threaten me. Her sole transgressions, if they even merited that label, had been to make unempirical claims about the bus’s imminent arrival, to persist in engaging me in conversation despite my disinterest, and to somehow discomfit me by behaving “crazily” without bearing stereotypical accoutrements of “craziness” like unkempt hair or filthy clothing. My mind began revisiting all of the occasions on which I had moved
from dishevelled passengers on subway trains, given a wide berth to fellow pedestrians who appeared to be talking to themselves, and backed exaggeratedly away from friends to imply in jest that they had done something “crazy.” The lavish extent to which my ability to perform mental health relied on others’ inability to do so suddenly came into sharp focus.

When I arrived at my friend Ana’s house—the regular meeting place of the anti-psychiatry reading group I had been attending—I described the above encounter to the eight other attendees present on that day, seven of whom identified as psychiatric survivors. Five said that they would have responded in roughly the same way that I did if they were in my shoes. Two said that they would have engaged the woman in conversation. One—Gracie, a chatty woman in her fifties—said that she was, more often than not, the “crazy lady” from whom others backed warily away.

Gracie had a distinctive habit of muttering to herself and compulsively kneading the web of flesh between her left forefinger and thumb while others spoke. She did this primarily when other people were talking to each other; it took me months to realize that this was her method of attempting to gain access to a conversation. When offering her opinions, she would start out by mumbling and gradually increase the speed and amplitude of her voice until her contribution began to resemble a rant. On many occasions, I found myself shifting uncomfortably in my seat as she fixed me with an unwavering, wide-eyed stare, seemingly oblivious to her surroundings. Whenever the conversation touched on a topic that she held especially strong feelings about, she would begin vocalizing her views whether or not others had completed their sentences; when speakers did not immediately cede the floor to her, she would fly into a rage. Sometimes, she would storm out, cursing us all. After spending twenty minutes nursing a cigarette or two, she would then return to her seat at Ana’s kitchen table as though nothing had happened, her effervescent demeanour fully restored.

Over time, I learned to accept Gracie’s quirks as a necessary and indeed invaluable part of the social experience that the reading group provided. However, at the outset of our acquaintanceship, she represented an unsettling presence to me, and she remains an embodied reminder of the extent to which judgements about mental health and illness link up with assessments of social competence. Gracie’s declination to perform the “politeness conventions” of the dominant speech community when conversing with others seemed to signal that she was either unable to understand those conventions or unwilling to apply them, and both possibilities were interpretable as manifestations of “serious psychiatric disability” (Mancini and Rogers

---

2 All informant names are pseudonyms. See chapter 2.
2007: 39, 35). In diagnostic parlance, she displayed a level of “grandiosity,” “distractibility,” and “psychomotor agitation” that could have been characterized as “manic” (American Psychiatric Association 2000: 362), and she had indeed once been diagnosed with a bipolar disorder. But she sniffed at the validity of the label, preferring her own analysis, which, over coffee and Nanaimo bars that chilly morning, she expressed in the following terms:

For Chrissake. I act funny. Yeah—so what? People have trouble with that? Always have, always will. Good for them. It’s not a job for fuck’s sake, it’s just my life.

This statement is analytically interesting for at least three reasons. First, it indicates that Gracie was able to analyze her past interactions with people, assimilate this information into a generality, and assemble a predictive model from it, thereby destabilizing the traditional view that people with bipolar disorder characteristically display “poor insight” about the causes and effects of their behaviours (Ghaemi et al. 1995: 464). Second, the distinction she draws between “a job” and “my life” tacitly challenges the equation of mental health and economic productivity that has become increasingly normalized in neoliberal societies (Hindess 2004; Rose 1998, 2001; see chapter 4). Third, and most importantly, it puts the onus on the people who are disturbed by “funny” behaviours to justify their objections, and it establishes “funny” behaviour as, in itself, an unremarkable thing—a key move in anti-psychiatric discourse. In so doing, however, it throws into sharp relief the scope of the problem that people in her position face, for her perspective on the validity of her diagnosis is not the perspective that holds sway in mainstream Canadian society.

Despite a proliferation of scholarly critiques in recent decades (see section 2.2 below), psychiatrization as a form of logic maintains a firm grip on the popular imagination. An Ipsos Reid poll commissioned by the Canadian Medical Association in 2008 revealed that 27% of Canadians surveyed are “fearful of being around people with mental illness” and 55% consider such people unmarriageable (Spurgeon 2008: a1447). The Ontario Human Rights Commission (2011: 6) disclosed in a recent consultation paper that “one-third to one-half of people with mental illness report being turned down for a job for which they were qualified after they disclosed their disability, were dismissed from their jobs, and/or were forced to resign as a result of their mental illness.” Narrative patterns and archetypes in film, theatre, television, advertising, news reportage, and editorial commentary throughout the country consistently assert the normalcy/benignity of some people by sensationalizing the deviancy/dangerousness of others, establishing these others as “objects of fear, derision, or amusement” (Lawson and Fouts 2004: 313), and encouraging audiences to reach conclusions about psychiatrized constituencies based...
on vicariously experienced plotlines and imageries. Within a cultural milieu that overwhelmingly urges untoward judgements about “madness,” and given the limited circulation and relatively small readerships of academic journals in which robust critiques of psychiatry are most likely to appear, prospects for a paradigm shift in lay thinking about mental disorder would seem to be dim.

Yet the social movement communities that have grown out of critiques like Gracie’s persist to this day, tenaciously and optimistically, with genealogies reaching back to the countercultural ferment of the 1960s. While participants in these communities have characterized their dissent in very different ways over the past several decades (“anti-psychiatry,” “mad liberationism,” “psychiatric inmates’ liberationism,” “the consumer/survivor/ex-patient movement,” “Mad Pride,” see chapter 3), have typically occupied a marginal niche within liberal and radical political circles, and have consistently faced widespread opposition and indeed public ridicule, the fluid networks of activists who work together to challenge psychiatric practices and psychiatrizing discourses have been able to maintain, if not a collective identity per se, a sense of camaraderie, common purpose, and morale. The transformative significance of such networks is palpable in the below statement by psychiatric survivor activist Jody Harmon, a member of the psychiatric disability advocacy group and human rights NGO MindFreedom International:

I’m a psychiatric survivor, and I don’t use that term loosely. I have been stored in warehouses labeled hospitals. I have endured weekly lectures termed therapy. I have been zapped until my brain burns white. I have been held down, tied down, put down. I have had pills forced down my throat and needles plunged into my flesh. All this to make me ‘normal,’ a mold I will never fit. … For awhile [sic] the system had convinced me that I wasn’t fully human and didn’t deserve any rights. Well, I learned how to use the internet two years ago at the library and suddenly found that there were other people who had gone through similar things, who were also abused and ostracized. Here were some people who listened to me and actually understood when I talked. I started feeling like a human being again (Harmon 2001: para. 1, 25).

For Harmon, as for Gracie, psychiatric diagnoses and interventions are neither vitalizing nor vindicating. But within a public sphere that is so heavily informed by news reportage linking mental illness with crime and biomedicine with progress, their views are easily dismissed as

---

3 The pageant of cackling psychopaths and amoral sociopaths that inhabit popular culture is vast and cannot be reviewed here. Some examples include Norman Bates of Alfred Hitchcock’s Psycho, Annie Wilkes of Stephen King’s Misery, Hannibal Lecter of Silence of the Lambs, Patrick Bateman of American Psycho, numerous antagonists in the Final Fantasy video game series, the hyenas in Disney’s The Lion King, Lisa Rowe in Girl, Interrupted, and virtually the entire rogue’s gallery of the Batman franchise. It is worth noting that mad villains tend not to be assigned specific diagnoses in Hollywood blockbusters—they are simply coded as “mad” through stereotypical signifiers like maniacal laughter, obsessive muttering, flamboyant bodily tics, unusual sartorial choices, or a ruthless lack of affect. However, sympathetic or pitiable characters do tend to be assigned specific diagnoses (e.g. John Nash’s schizophrenia in A Beautiful Mind, Howard Hughes’s obsessive compulsive disorder in The Aviator, Virginia Woolf’s bipolar disorder in The Hours, Nina Sayers’ anorexia in Black Swan). This pattern reinforces an ostensible distinction between “good” madness, which is knowable and surveillable through medical labels, and “bad” madness, which, unlabeled and unsurveilled, represents a danger to society (see chapter 6).
eccentric, dogmatic, fanatical, or, if somewhat understandable, then still unduly biased. In a *National Post* article on a May 2010 Toronto anti-psychiatry conference, for example, psychiatric survivors were characterized as “delusional,” “rambling,” “self-absorbed,” “crackpot,” and “dupes” (Brean 2010: A1, A8, A10). In an interview with the *National Post*, University of Toronto historian Edward Shorter described the conferees as being engaged in “all kinds of nuttiness,” despite the fact that their critiques of psychiatry echoed some of his own (e.g. in Kleiner 2011, an interview in which he expressed misgivings about the increasing medicalization of culturally normal behaviours). How can we make sense of the persistence and repeated rebirth of grassroots anti-psychiatry movements (broadly defined) over the past four decades in light of the enormous support and legitimacy that psychiatrizing discourses enjoy within mainstream culture? What makes psychiatric survivors’ firsthand accounts of maltreatment and resistance so readily dismissible as “delusional” or “nutty,” when critiques of psychiatry have long proliferated in the humanities and social sciences? Why, ultimately, are some people’s knowledge claims considered credible while others’ are not?

### 2.2 Anthropologies of Psychiatry: Themes, Trends, and Trajectories

There is a rich body of anthropological literature on psychiatric etiologies and nosologies, much of which deftly challenges the notion that madness is necessarily rooted in chemical imbalances and congenital predispositions. This literature tends to fall into four overlapping genres: research on the *social and linguistic construction* of particular disorders (e.g. ethnographies of clinics); research on the *political economic causation* of particular disorders (e.g. studies of structural inequalities and their mental health outcomes); research on *alternative epistemologies* for understanding acts and affective states that have deviant associations in the West (e.g. psychoanalytic or political interpretations of trance and spirit possession); and research on the *ideological and material serviceability* of psychiatric technologies to colonial, imperial, and industrial projects (e.g. cultural histories of diagnoses or practices that have served as pretexts for exploitative enterprises). Below, I review broad analytic trends and findings in each genre and stake out a position within current debates about the medicalization of psychic distress. I then discuss some of the ways in which disciplinary divisions can obscure important conceptual linkages to which scholars who study psychiatristized populations should pay close attention.

---

4 Respectively, the study of how diseases originate and develop and the study of how to define, diagnose, and classify diseases (MedlinePlus.gov, U.S. National Library of Medicine 2010).
Social and linguistic constructivist studies offer detailed portraits of the way in which “mental illness” identities emerge from daily interactions, whether with medical clinicians (Barrett 1988, 1996; Gremillion 2003; Mattingly 2004; Luhrmann 2001; Young 1995, 2004), social workers and community counsellors (Carr 2011, Desjarlais 1997, Estroff 1992), family members (Capps and Ochs 1995, Capps 1999), or cultural artifacts like magazine articles, television programs, and other texts (Danforth and Navarro 2001, Lakoff 2000, Martin 2007). In Robert Barrett’s (1996) exploration of documentary practices on an Australian psychiatric ward, for example, newly admitted patients who complained of bodily discomforts, family conflicts, social difficulties, and sundry other preoccupations were transformed, through the application of standardized interview protocols and note-taking conventions, into “schizophrenics” with predetermined prognoses and clearly defined treatments. Allan Young describes similar processes at work in an American veterans’ hospital, in which Post-Traumatic Stress Disorder (PTSD) was “glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented” (1995: 5). Young observed that clinicians’ inflexible adherence to psychomedical models became a source of profound anguish to diagnosed veterans, who were repeatedly made to recite narratives about their trauma, guilt, and anger in ways that they found punitive and unhelpful. While the initial purpose of the PTSD label was to facilitate veterans’ access to disability compensation, it gradually came to represent a set of therapeutic givens: trauma is now conceived a neurological fact and object of medical expertise that cannot be dislodged without the aid of mental health infrastructures.

Young’s broader point, that scientific facts cannot be divorced from “the social, cognitive, and technological conditions through which researchers and clinicians come to know their facts and the meaning of facticity” (1995: 10) is richly illustrated in Lisa Capps and Elinor Ochs’ (1995) study of patienthood and language. Their book is distinctive in its focus on one particular agoraphobic woman and the daily routines of her life. Through careful analyses of the woman’s conversations with family members, and the requests, desires, and anxieties embedded in them, Capps and Ochs show how the agoraphobic patient identity is an artifact of verbal transactions that position fearful speakers (often women) as irrational or hypersensitive, while positioning their interlocutors as voices of reason. In an insightful analysis of social service agencies for drug users in a Midwestern American city, Summerson Carr (2011) advances similar claims about the linguistic construction of addiction. At the outpatient drug treatment program she studied, “therapy was focused on reconfiguring clients’ relationship with language rather than simply, or even primarily, reconfiguring their relationship to drugs” (2011: 3), and
addicts thus quickly learned how to pay lip service to their therapists’ preferences without having to follow through in practice. By telling formulaic stories about denial, acceptance, and recovery, drug users gained their evaluators’ trust and, through it, access to a wide range of social services.

Anthropological work on the political economic dimensions of mental health have tended to focus on the psychological hardships that socioeconomic and geopolitical inequities and indignities impose on particular constituencies: among drug dealers and addicts in New York and San Francisco (Bourgois 2003, Bourgois and Schonberg 2009), among working- and middle-class Argentines during an economic crisis (Lakoff 2005), among upwardly mobile Batswana during an economic boom (Livingston 2009), among impoverished residents of a Brazilian shantytown (Schepers-Hughes 1992, 1993), among Irish farmers during the collapse of the local agrarian economy (Schepers-Hughes 1977), among Hispano heroin addicts in New Mexico (Garcia 2010), and among urban homeless populations (Baer et al. 2003). Andrew Lakoff, for example, describes a link between Argentina’s economic recession of the 1990s—which was marked by a national unemployment rate of 20 percent—and the country’s skyrocketing anxiolytic drug prescription rates during the same period (2005: 134). Within twelve months at the peak of the crisis, antidepressant sales leapt 16.5 percent (Lakoff 2005: 135). Stressed and suicidal Argentines who lacked private health insurance were denied therapeutic alternatives to drugs, thus creating a captive market for local and multinational pharmaceutical firms. During her fieldwork in rural Brazil, Nancy Schepers-Hughes (1992) similarly found that hunger had been normalized to such a degree that it was no longer understood in nutritional terms, but was, rather, acknowledged only in its final, debilitating stages—as “delirio de fome” (“hunger-madness”), a psychotic state that arose from prolonged starvation, manageable only with the aid of tranquilizers, painkillers, and sleeping pills. The problems with conflating social inequality and mental instability are also examined in Philippe Bourgois’ (2003) study of the underground crack economy in East Harlem. Bourgois paints an intimate portrait of his informants’ daily lives, which are rife with substance use, gun crime, domestic violence, rape, and murder. By tracing the ways in which geographic and historical injustices created the conditions for his informants’ gendered resentments, racialized humiliations, and class-based frustrations, Bourgois shows that self-destructive behaviours are ultimately more attributable to people’s internalization of structural and symbolic violence than to sociopathic or psychopathic impulses.

In contrast to modern narratives about biological psychiatry’s rehabilitative powers, many anthropologists have discovered that the longer people stay in psychiatric healthcare systems, the more sensitized they become to the low expectations associated with their diagnoses
(Estroff 1992) and that biodeterministic conceptions of mental ill-health thus lead to worse outcomes in the West than in locales where it is perceived as ephemeral and family supports are more accessible (Good 1997; Eguchi 1991; Hopper 1991, 2004; Luhrmann 2007, 2008). Anthropological work on alternative epistemologies for understanding madness accordingly provides substantial counterevidence to the claims that mental disorders are biological diseases that manifest identically everywhere (e.g. Applbaum 2009, Kirmayer 2002, Littlewood 2002), that mental health is neatly separable into biological and social components (e.g. Kleinman 1988), that cultural idioms like trance or spirit possession map smoothly onto DSM nosologies (e.g. Jenkins and Barrett 2004; Boddy 1992; Lambek 1992, 2010), and that “mental illnesses” are invariably negative and unwanted experiences (e.g. Gooldin 2008, Warin 2010). For instance, Sigal Gooldin (2008) has shown how anorexic Israeli women use wartime analogies to define their self-starvation as a project of resistance against others’ agendas and impositions. Megan Warin (2010) has similarly revealed that disordered eating habits can ratify practitioners’ sense of personal worth and allow them to evict feelings of shame, becoming an ally in times of need, and facilitating important social relations.

Gooldin’s and Warin’s findings resonate with a growing body of ethnographic literature on why and how some people gravitate to stigmatized lifeways that are publicly condemned as irrational but that can, in fact, be seen as intensely rational when considered against a backdrop of unobvious costs and benefits (not just economic, but social, relational, and moral; see also Obeyesekere 1981, Wardlow 2006, Aretxaga 1995). As contemporary and historical studies of psychiatry’s ideological serviceability to exploitative ventures disclose, psychiatric labels not only serve to depoliticise the dilemmas of such individuals, they have furnished commercial drug manufacturers with astronomical profits (Applbaum 2009, Petryna and Kleinman 2006) and supplied ruling elites with politically satisfying explanations for events like prison revolts, slave escapes, mass uprisings, and armed anti-colonial resistance: protestors are said, simply, to have gone mad, thus justifying psychiatric scrutiny and carceral interventions (Fassin 2011, Keller 2011). As some anthropologists have shown, the goal of importing medical knowledge from the West to the Rest served as a powerful legitimizing discourse during the heyday of colonialism (McElhinny 2005, Stoler 2002). By producing voluminous studies of the ways in which indigenous populations (ostensibly) “lacked the sustained self-control and capacity for reason necessary to become fully civilized,” Western psychiatrists and psychoanalysts offered colonial authorities seemingly unimpeachable alibis for their continued presence in the tropics and elsewhere (Anderson 2006: 141-142). Similar rationales persist today in the form of Western
development initiatives that fixate on the psychological dimensions of war crimes, civil conflicts, illiberal market practices, illiteracy, and non-Western hygienic practices, which “not only reduce a person to a trait, turning him or her into a ‘case’ or abnormality to be treated, but also make it possible to dissociate explanations of the ‘problem’ from the nonpoor and to assign them to factors internal to the poor” (Escobar 1991: 667; see also Summerfield 1999). In chapter 3, I offer a fuller account of psychiatry’s serviceability to colonialism and the reactions of those underfoot, which tend to be omitted in traditional histories of anti-psychiatric resistance.

In sum, anthropological investigations have generated crucial insights about the social contexts and consequences of psychiatric knowledge claims. Such investigations nonetheless tend not to dispute the notion that psychiatry today offers validating interventions that are, for the most part, acceptable to patients in the West. On the one hand, it is precisely because psychiatric vocabularies do in fact permeate most corners of civil society that ethnographic work on the socio-political dimensions of medicalization is so timely and important (e.g. Danforth and Navarro 2001 on the rise of the ADHD diagnosis, Martin 2007 on portrayals of bipolar disorder in American popular culture). On the other hand, scholarly revelations about psychiatry’s transformative influences on public and private institutions do not require us—even if they may invite us—to ask how psychiatric methods and medications might, in fact, be inflicting serious somatic or existential harms on individual patients. As Richard Keller (2011: 199) observes,

> We most often imagine medicine as a healing art, a means of alleviating pain. And yet, what of a scenario in which medicine is a primary source of—or is at least as coextensive with—suffering and trauma? Since Michel Foucault’s critical framings of clinical knowledge and medical power, social scientists and humanists have exhaustively explored the production of biopolitical knowledge and its implications for modernity. Yet, a concern for exposing the operation of medical power has produced fewer examinations of medicine as an explicit source of suffering.

This gap in the anthropological canon manifests in two ways: a lack of attention to iatrogenesis in the present day (adverse effects and ailments resulting from medical treatments) and a lack of attention to the collective activisms of people who have endured iatrogenic complications, which together reinforce the idea that “mentally ill” people cannot accurately assess themselves. Perhaps as a partial consequence, there are currently few anthropological studies of anti-psychiatric movements, with the main exception of Gabriella Coleman’s (2008) analysis of psychiatric survivor counterculture in the United States.

This inattention to anti-psychiatric mobilization has been partly rectified by the recent work of two sociologists, Nick Crossley (2004, 2006) and Linda Morrison (2005), whose contributions I discuss in more detail in chapter 3. In general, while it is not possible to supply a complete review of the multidisciplinary literature here, it must be noted that sociologists,
historians, philosophers, critical disability theorists, science and technology theorists, feminist psychologists, and dissident physicians have produced many landmark critiques of psychiatry whose influences transcend traditional field boundaries, often percolating into the arguments of both anthropologists and anti-psychiatry activists. Notable examples include Michel Foucault’s (1965, 1979) theorizations of deviance and its management, Phyllis Chesler’s (1972) work on the pathologization of women’s experiences, David Healy’s (1997, 2002, 2006) work on commercial influences on clinical trial processes, Nikolas Rose’s (1998, 2001, 2003, 2004) work on the ways in which psychological terminologies and technologies shape citizenship claims, Ian Hacking’s (1999, 2002) work on the co-emergence of diagnostic labels and their recipients, Andrew Scull’s (1984, 1989, 1993, 2006) work on the historical transformation of Western custodial institutions, and Frantz Fanon’s (1963, 1967) work on the pathogenic nature of colonialism. Each of these scholars has produced oeuvres with considerable cross-disciplinary resonance. Indeed, the ethnographic literature on psychiatry is replete with references to interdisciplinary studies about the ethnocentric, androcentric, or homophobic features of past and present DSM diagnoses (e.g. Caplan 1996, Kutchins and Kirk 1997, Kirmayer 2002, Prior 1999), the serviceability of psychological research to ruling elites in the metropole (e.g. Herman 1996, Metzl 2010) and the colonies (e.g. Anderson 2006; Loomba 2005; Vaughan 1991, 1993, 2001), and the influence of commercial interests on psychiatric research priorities (e.g. Paris 2008).

Much of my dissertation is accordingly informed by non-anthropological scholarship, not only because of its topicality, but as part of a broader effort to avoid reproducing the same blind spots that biopsychiatric discourses foster when they arbitrarily cleave some parts of human experience from others. As illustrated in the example below, in which a researcher phones a discharged psychiatric patient to arrange an interview, artificial subject distinctions can be highly serviceable to reductive illness models:

Ed refused, saying, “All that mental patient stuff is behind me. That’s part of my past, and I just don’t want to be reminded of it. I don’t belong in your study anymore. I’ll be glad to consult with you about computers, and work on your project computer system, but I don’t want to talk about all that—those questions you ask me. It isn’t necessary or fun anymore.”

I accepted his refusal and recalled privately his discomfort (and mine with his) during previous discussions about whether he thinks he is mentally ill or not, and his preference for talking about politics and philosophy instead of completing the interview symptom scales. He had been harshly critical of the interview questions that concerned stigma, labeling, and patienthood. At one point he suggested that we add a category of “irrelevant question” to the answer options. I asked if I might call again in six months and he said, “Sure, I don’t mind talking to you, but just not about all that.” (Estroff et al. 1991: 334; emphases mine)

Ed’s strenuous efforts to avoid being pigeonholed as a “mental patient” are evident throughout the above excerpt, and his consequent withdrawal from the study incurs a loss of data that might
have been collected from “the interview symptom scales” and predetermined questions about “stigma, labeling, and patienthood.” Yet, in his own way, Ed is actually furnishing his observers with valuable data about his patienthood. He repeatedly expresses a willingness to discuss non-psychiatric topics related to his life, priorities, skills, and worldviews—factors that are deeply implicated in debates about mental health outcomes—and his firm rejection of the patient identity hints at many potentially fertile lines of inquiry about his psychiatrization experience. To treat Ed’s “preference for talking about politics and philosophy” as separable from his patienthood is to treat clinical taxonomies as pre-theoretical and, thus, unassailable. As a major aim of this thesis is to destabilize biomedicine’s jurisdictional authority and thus reveal the coextensive nature of “politics… philosophy” and psychiatry, disparate bodies of scholarship will necessarily converge in the chapters that follow. By adopting a cross-disciplinary approach, I hope to enrich anthropological arguments about the textual construction, structural causation, and ideological function of “mental illness” labels; to shed light on how “madness” is a sensible response to tightly constrained lives that teem with racialized, classed, gendered, and other indignities; and to explore the politicized, collectivized outrage that doctors, relatives, and society at large can ignite by ignoring (or denying) iatrogenic symptomatologies and demanding patients’ compliance at all costs. Before embarking upon an analysis of a counter-hegemonic struggle, however, a brief review of past and present work on collective resistance is necessary.

2.3 Instrumentalizing Identities: Social Movements and Their Analysts

The social movement literature exhibits some curious traits. After the decline of mob psychology models in the early 1970s, Euro-American theorists devoted significant energies to the task of fine-tuning taxonomies of participants’ hypothesized motives (Flacks 2005, Meyer 2004: 126-131). The crystallization of three competing schools of thought in the 1980s and 1990s—the American “Resource Mobilization” school (McCarthy and Zald 1977), the European “New Social Movements” school (Laclau and Mouffe 1985, Touraine 1985, Melucci 1980), and the transatlantic “Political Opportunity Structure” school (Gamson and Meyer 1996)—did not diminish theorists’ longstanding preoccupation with the question of what motivates activists to engage in activism, leaving undertheorized the socio-historical and geopolitical inequities that quite naturally enflame popular dissent (Cohen and Rai 2000; see also Pichardo 1997). This preoccupation has led to a social scientific canon in which activists’ well-documented and repeated willingness to endure arrests, police brutality, hate mail, FBI scrutiny, criminal records, and derailed careers in pursuit of their political aims is routinely treated as counterevidence for
“rational choice” explanations of collective action. In short, central to a substantial body of social movement scholarship is a sharp distinction between activism and rational “self-interest,” ostensibly borne out by the observation that political dissenters’ priorities do not resemble those of a macroeconomic caricature, *Homo economicus* (Edelman 2001: 288).⁵

My intention here is not to trivialize this type of theorizing, but to politicize it: not only does the preoccupation with activists’ material incentives disclose a dependence on narrowly economistic definitions of rationality that delegitimize individuals’ lifelong commitments to their causes (Flacks 2005: 11), it fortifies an image of “value-free social science” that absolves scholars from their complicity in the very systems that many political dissenters find problematic (Croteau 2005: 24). Moreover, by evaluating movements’ successes and failures chiefly in terms of their capacity to effect material reforms rather than broader cultural and epistemic transformations, these rational choice models obscure the less tangible rewards that accrue to movement actors (e.g. feelings of solidarity, affirmation of marginalized life experiences; Edelman 2001: 290). Among anthropologists and sociologists, a consensus has emerged in multiple venues that collective action is far messier and more fractious when examined from up close, and that the “false circumscription and coherence” of macroscopic theories “masks significant interactions between the individuals of that community and others, as well as the heterogeneity of the community itself,” which may divide, reassemble, and metamorphose in unexpected ways (Wilson and Peterson 2002: 455). Consequently, my work aligns with that of other ethnographers who, in eschewing overly enumerative frameworks, have sought out approaches that “resist ‘grand theoretical’ generalizations” (Edelman 2001: 286) and accommodate “alternate forms of collectivity” that might offer a theoretical counterweight to the traditional focus on material gains (Coleman 2010: 490; see also Coleman 2009).

Some analysts have tackled this problem using the prism of “identity politics,” which makes visible the strategic essentialisms that enable collectivist critiques of, for example, gendered, classed, racialized, ethnicized, heterosexist, transphobic, or ableist iniquities. Because of the multidimensional nature of identity, such essentialisms are understood to be situational, rather than immutable, and always disposed to reconstitution along other lines of allegiance or

---

⁵ This theoretical trend has been resilient. Well into the 1990s, Byrne (1997: 10-11) put forth a schema describing four diagnostic features of social movements: irrationality (“adherents do not seem to be motivated by self-interest or material advantage”), unreasonability (“adherents appear to think they are justified in flouting the law or disregarding ‘normal’ ways of doing things”), disorganization (“they deliberately refrain from formalising their own organisations, even when it would seem advantageous to do so”), and unpredictability (“environmental movements have not always developed in societies with the greatest environmental problems”).
affinity (Bernstein 2005). This theoretic turn solves two problems: it makes visible the ways in which marginalized constituencies experience their lives within a dominant culture, and it gives more weight to the logics that ordinary people deploy when debating “who members of the group are, what their attributes are, what they have in common, how they are different from other groups, and what the political significance of all this is” (Whittier 2002: 302). Polletta and Jasper (2001) thus argue that the construction of a “collective identity” is typically an early move in any social movement, whether implicit or explicit, as it enables participants to gravitate toward each other, identify allies and opportunities, build coalitions, and make effective use of interpersonal and informational networks (see also Meyer 2004). Analysts of social movements “as diverse as multiculturalism, the women’s movement, civil rights, lesbian and gay movements, separatist movements in Canada and Spain, and violent ethnic and nationalist conflict in postcolonial Africa and Asia” have accordingly found identity debates central, even preconditional, to subsequent debates around aims, agendas, tactics, and ethics (Bernstein 2005: 47).

Nonetheless, as political philosopher Nancy Fraser (1997: 113) has noted, the term “identity politics” has acquired a secondary valence in some activist/academic circles, in which it is “increasingly used as a derogatory synonym for feminism, anti-racism, and anti-heterosexism,” as well as maligned for enabling “political tribalism” (Melucci 1989: 209, quoted in Edelman 2001: 299). Activists and academics alike are routinely critiqued in two ways when militating against cultural vectors of privilege: they are accused of engaging in divisive, sectarian, and factionalizing behaviour that undermines the solidarity of “the” progressive community, and they are accused of failing to recognize the primacy of economic inequality, to which the indignities linked with living in female, racialized, queer, or disabled bodies are (ostensibly) ultimately reducible. In a revealing debate in New Left Review, feminist poststructuralist Judith Butler (1998: 39) pointed out that although Fraser had been right to observe that “identity politics” has become a trivializing slur in many leftwing circles, Fraser herself “reproduces the same division that locates certain oppressions as part of political economy, and relegates others to the exclusively cultural sphere.” Fraser (1997) had previously argued that, because gays and lesbians do not form a distinctive sector in the societal division of labour, homophobia was not essentially rooted in materialist inequality. In her critique, Butler argued that Fraser’s stance relied on the problematic notion that political dissidence must always operate along a continuum with class and culture on opposite ends. Because the heteronormative regulation of sexuality was instrumental to the rise and legitimization of capitalist modes of production, in which private/public divisions of labour came to fall along gendered lines,
homophobia is in fact deeply rooted in, and has always been nourished by, an unequal political
economic landscape (Butler 1998: 39-43). In her response, Fraser (1998: 142) asserted that

Opponents of heterosexism need not labour to translate claims of sexual status injury into claims of class
deprivation in order to vindicate the former. Nor need they show that their struggles threaten capitalism in
order to prove they are just. … far from claiming that cultural harms are superstructural reflections of
economic harms, I have proposed an analysis in which the two sorts of harms are co-fundamental and
conceptually irreducible. From my perspective, therefore, it makes no sense to say that heterosexist
misrecognition is ‘merely cultural.’ That locution presupposes the very sort of base-superstructure model,
the very sort of economic monism, that my framework aims to displace.

Of particular interest in the above debate is the distinctive way in which each author repudiates
their leftwing colleagues’ attacks on “identity politics.” For Butler, identitarian grievances are
valuable because they illuminate subtle historical injustices that tend to be sidelined in mainline
debates about distributive injustices. For Fraser, identitarian grievances about quotidian
inequities (“to be denied the status of a full partner in social interaction and prevented from
participating as a peer in social life,” 1998: 141, emphases in original) are no less serious than
distributive injustices, and are irreducible to the latter. Their respective positions are not
incompatible: both of their arguments have merit, can be built upon in diverse ways, and shed
valuable light on the multiple vectors through which human beings experience indignity. Neither
Butler nor Fraser, nor their supporters, have to be persuaded by the other’s position for their
debate to enrich the explanatory repertoires of their respective fields. In a similar vein, a
recurring thematic in this dissertation is the epistemological productivity of internal conflict in
political communities, as seen in instances of discord between actors and organizations with
intersecting identity claims. Contrary to popular wisdom on the Left, in which infighting is
widely lamented as counterproductive, irreconcilable ideological differences and irreparable
interpersonal rifts between activists are rarely avoidable and not always destructive. The fact that
all people face a “multiplicity of roles and plethora of pressures” is precisely what equips them
with the heterogeneous forms of technical and social capital that make political movements
possible; the fact that contributors will almost certainly harbour heterogeneous aspirations and
grievances that eventuate in conflict is simply part of the deal, so to speak (Chhachhi and Pittin
1999: 74), and may in fact sensitize them to issues that invite further activism.

The identity paradigm in social movement research acquires an additional wrinkle when
applied to psychiatric survivors who resent classification schemes and who know firsthand what
can happen when one relinquishes control over one’s life story. On numerous occasions, my
informants’ strenuous resistance to being pigeonholed into pre-existing identity labels brought to
mind Ludwig Wittgenstein’s famous meditation on madness: “You must always be puzzled by
mental illness. The thing I would dread most, if I became mentally ill, would be your adopting a common sense attitude; that you could take it for granted that I was deluded” (quoted in Drury 1981: 161). As Gamson (1995: 390) points out, focusing excessively on the creation and maintenance of collective identities diverts valuable attention from “the simultaneous impulse to destabilize identities from within.” This observation throws into focus some fundamental dilemmas of the framework: collective identities are a basis for both solidarity and oppression, members do not always agree on inclusion criteria, and a person’s claim to a particular identity can be refuted by “expert” observers who do not themselves lay claim to that identity. Researchers who study individuals located at the intersection of multiple categories (disability, gender identity, sexual orientation, religion, race, ethnicity, diasporic identity, socioeconomic class, geographic location, etc) rapidly find themselves uncovering invisible constituencies whose embodied experiences are poorly articulated and sometimes denied outright by the representational tools of both scholars and movements (Valentine 2007). While social movement actors often need to reify “collective identities” in order to explain the systematic nature of their marginality and achieve tactical gains, these identities are always ambivalent and tentative, and “they do not determine the complex texture of day-to-day life for individual members of the social group under study, no matter how detailed the level of disaggregation” (McCall 2009: 57).

To return, then, to the questions of when, where, and whether solidarity and continuity are sustained in anti-psychiatry communities when the “anti-psychiatry” rubric is under continual assault from both without and within, we need to understand how people manage the problem through continual processes of philosophical, political, rhetorical, and emotional work. I suggest that the turn to “collective identity” in social movement research, while useful as an interpretive tool, does not adequately capture the formidable constellation of skills that people deploy when collaborating as insiders who share crucial types of firsthand experiences (e.g. psychiatric hospitalization; knowledge of how it feels to be on certain psychotropic drugs) and, simultaneously, establishing themselves as eternal outsiders whose experiences can never map readily onto others’. The ambivalent nature of collective identity construction in anti-psychiatry communities is underscored by Luhrmann’s (2001: 10) timely reminder that, because there are currently no diagnostic tests for psychiatric disorders, those who study “psychiatric ways of seeing” have a special responsibility “to proceed knowing that what counts as ‘fact’ is a tinted window onto a world you cannot step outside to see.” This is true of both psychiatric “ways of seeing” and anthropological ones: the fact that anthropologists have excelled at making sense of stigmatized and pathologized forms of logic does not mean that our classifications would be
recognizable to, or ratified by, our informants. As will be seen in later chapters, psychiatric survivors are acutely averse to the suggestion that their experiences are neatly classifiable, enumerable, or analyzable (as one informant put it when denying his classifiability, “I’m just a person”). Not one of the three organizations with which I worked required members to pledge overt allegiance to any explicit collective identity, and members routinely affirmed that “all” were welcome to attend, so long as they respected the right of psychiatric survivors to define their own experiences. However, this did not stop members from exercising disaggregating and delegitimizing logics when faced with the need to set themselves apart from other group members, sometimes because they felt that an overly ecumenical acceptance of “all” aspiring participants served to trivialize the exceptional traumas of a few.

3. Organization of the Thesis

3.1 Outline of Chapters

In the next chapter, I will introduce readers to my fieldwork setting and describe the modes of data collection that enabled my work with three distinct groups in what can broadly be called the Greater Toronto Area’s (GTA) anti-psychiatry community. Not all of my informants considered themselves “activists” despite, in some cases, having a long history of participating in initiatives traditionally glossed as activism (e.g. attending rallies and political demonstrations, starting/signing petitions, boycotting certain companies, subscribing and writing to leftwing newsletters, “culture jamming” by editing publicly displayed advertisements). Others who had identified as activists in their youth had long put their “radical days” behind them. Yet, most did see the hardships they had endured within psychiatric systems as having helped them, at one point or another, to discern meaningful solidarity in each other’s company and in explicit opposition to psychiatry. Moreover, virtually all made use of the umbrella term “the movement” at least once (or regularly) when reflecting on their and their peers’ shared grievances.

Chapter 3 establishes the above observation as a key problematic in my research. When people position themselves as resistors of psychiatry, what is meant by “psychiatry”? I answer this question by unpacking the ideological continuities and discontinuities that have shaped the activities and trajectories of North American anti-psychiatry, mad liberationist, psychiatric inmates’ and psychiatric consumer/survivor/ex-patient movements over the past four decades. I first review the history of Western psychiatric innovations such as inpatient facilities and standardized diagnostic codes whose emergence set the stage for the rise of anti-psychiatry movements and counterculture in the mid- to late twentieth century. I then contextualize the in-
the-moment debates and discussions preserved in copies of a major American anti-psychiatry newspaper (*Madness Network News*, 1972-1986) and a Canadian anti-psychiatry magazine (*Phoenix Rising*, 1980-1990) within secondary historical accounts and the recollections of former participants. In so doing, I reveal how a rapidly shifting political landscape eventuated the demise of certain strands of anti-psychiatry during the 1980s, exacerbated ideological rifts in others, and introduced new ethical and tactical quandaries that are debated to this day.

Chapter 4 investigates the news media’s recent systematic and widespread portrayal of “mental illness” as a financial liability and a threat to civil society. By analyzing a corpus of 607 news items published from January 2006 through January 2011, I argue that while this portrait has served to mobilize institutional stakeholders—insurers, employers, courts, and corporations—against the national “epidemic” of depression and anxiety, it also displaces alternative readings of this epidemic that might signal more recalcitrant problems with the structure of our society. In particular, I argue that an image of “mental illness” as an economic and existential threat has crystallized in Canadian public discourse with the aid of a broad moral narrative about real and counterfeit people, in which a monolithic force called “mental illness” is said to usurp its victims’ minds but remain distinguishable from their authentic selves. While clearly intended to tap into news audiences’ humanitarian impulses and empathies, I suggest that this narrative reinforces, rather than combats, the stigma surrounding psychiatrized life experiences by casting psychiatrized people as frauds in their own bodies and encouraging the public to view the “mentally ill” with pity and suspicion.

Chapter 5 contemplates a variety of ways in which psychiatrized people may come to discern philosophical value in their madness experiences (e.g. depression, suicide ideation, obsessive compulsions, sensory hallucinations, unempirical beliefs, sundry phobias and anxieties) and advances a conception of mental illnesses as embodied states that may be more pedagogical than pathological. I first explore the “madness debuts” of several informants whose pre-psychiatrized lives involved stressors and pressures that eventually made rage, recidivism, escapism, and performed unruliness seem more attractive than normalcy. I then unpack the inadequacy of conventional narratives about “mental illness” in which timely psychopharmaceutical intervention is said to lead organically to mental health. Because my informants’ madness experiences were meaningful to them, and because medical treatments tended to entail both the delegitimization of this meaning and the introduction of disturbing side effects, it was quite rational—and not a symptom of “poor insight”—that most eventually came to reject both medicalization and medication.
Chapter 6 extends the above finding by reviewing several examples of what I call “transgressive recoveries” from mental health difficulties, in which individuals successfully reclaimed satisfying lives by rejecting rather than accepting biopsychiatric interventions. By revealing the inseparability of medicalized traits and behaviours like “lack of insight” and “non-compliance” from factors that transcend the medical purview (e.g. accessibility of information, availability of nutrition and housing, nature of internal family dynamics), I argue that mainstream psychiatry’s preoccupation with the unreliability/inauthenticity of its patients’ thoughts and intuitions has led to a situation in which dissatisfied patients feel obliged to playact compliance, conceal their true actions and ambitions from suspicious friends and family, and disengage from medical systems in secret. Weary of condescension and wary of coercion, psychiatric survivors—and parents of psychiatrized children—can often find sympathy and solidarity only in each others’ company. This chapter’s analysis is intended as a partial corrective to two widespread, interlocking beliefs: that psychiatrized deviance must be either an illness or a weakness, and that biodeterministic explanations of deviance therefore absolve people from moral judgements. As I hope to show, rather than reintegrating the “mentally ill” into their communities, biodeterministic frameworks can instead compound their isolation and make them more, not less, vulnerable to moralistic critiques.

Chapter 7 has a dual objective. I first probe a set of ethical questions with which psychiatric survivors have had to contend in light of recent revelations about the risks of Selective Serotonin Reuptake Inhibitor (SSRI) usage and unsupervised withdrawal. Namely, when a person is said to be in an “altered state,” what level of responsibility do they bear for their thoughts and deeds? Can psychoactive substances create wholly new intentions, compulsions, and beliefs, or do they merely amplify what is already there? By looking closely at a conflict between two key players in a survivor peer support group that ignited around this issue, I then evaluate the social dynamics through which collective identity is policed, negotiated, and contested in modern anti-psychiatry communities. With the recent rise of the Mad Pride movement, psychiatric survivors have increasingly sought to establish “sanism” (systemic prejudice against psychiatric survivors) as a type of bigotry on par with racism and sexism. Although celebrations of “Mad” people’s creative achievements have offered psychiatrized individuals an alternative source of cultural capital, the categorical distinction between sanity and madness on which some activists insist can serve to obscure important similarities between the “sane” and the “mad,” and erase important differences, such as gender and race, within “Mad” communities. Of particular significance in this regard is the way in
which accusations of sanism can end up marginalizing psychiatricized individuals who have never endured certain genres of treatment (e.g. firsthand experience with SSRIs), a disproportional number of whom may be racialized. In documenting the above events, I seek to unsettle the reification of identity labels that insist on the equivalency of all forms of marginality, and show how irresolvable debates about the nature of volition, justice, and unobservable suffering may enhance the likelihood of intra-movement conflict.

3.2 Regarding the Author’s Positionality

It is worth making explicit my own point of view in this endeavour, as a critic of psychiatry whose scholarly gaze is informed by more than mere curiosity. While my own experiences with difficulties of a “psychiatric” nature are largely beyond the scope of this discussion, I cannot deny that it is from those experiences that my research interests have emerged. Since the age of twelve, my life has been fiercely inflected with what the DSM calls “depression” and all of its attendant symptomatologies. Because critics of psychiatry are often accused of denying the existence of madness and suffering (see Szmigiero 2009, Young 1995: 10), I want to make it clear that inescapable mental anguish—the kind of obliterating pain that makes climbing out of bed feel impossible—is, for me, an intimately familiar mindset. It was precisely the significance of this mindset to so much of my life that led me to populate my timetable with anthropology classes during my undergraduate degree: I became enthralled with the historiographic tools and geopolitical knowledges I was acquiring from those classes, which in concert destabilized a belief I had resolutely held as a teenager, namely that I was genetically defective and this was why I was depressed, self-destructive, and “crazy.” Reading ethnographic literatures that challenged commonsensical notions about a wide variety of topics—development, imperialism, history, science, social Darwinism, gender, race, and health—did not always relieve my sadness, but did disabuse me of the assumption that it signified little more than a sick brain, or that it was pathological for privileged First Worlders to feel anything less than optimism and motivation.

In The Vulnerable Observer: Anthropology that Breaks Your Heart, Ruth Behar writes of spending a year in a body cast following a childhood car accident. “I had always known that one day I would tell the story,” she confesses, and yet “I kept censoring it, wanting to remain loyal to the adult injunction not to make too much of the whole thing” (1996: 125). Acknowledging her own complicity in the stigmatization of those who disclose emotional vulnerability, Behar notes that, in adulthood, she often became irritated with friends who showed sympathy upon hearing this story, as she herself had “no sympathy” for the sad child in the cast: “She had been a
crybaby and a coward and I was ashamed of her” (1996: 125-126). Behar’s words have particular resonance to those of us with firsthand knowledge of what is called mental illness. We live in a society that values resilience, and, knowing this, we often find ourselves using sanitized terms like “mental health issues,” “psychiatric problems,” or any of the hundreds of DSM nomenclatures whenever obliged to account for our apparent lack of resilience (e.g. to explain gaps on a résumé, to justify lapses in productivity, etc). Forced to navigate the false dichotomy of illness and weakness, many of us find it easier to elect silence. Outside of this dissertation, for example, I rarely talk about my depression, having come to recognize the durability of labels like “coward,” and also because, as a product of my society, part of me genuinely believes that my depressed self is exactly that. There is an important linguistic consideration at play here: even though euphemisms like “clinical depression” are meant to discourage moral judgements, they also strip away the phenomenological texture and biographical details that reveal how common and understandable “mental illness” can be, thereby reinforcing the perception that it is aberrant. And so, to capture my own experience’s semantic richness and to frustrate biomedicine’s purview over it, I have deliberately characterized it as “anguish” and “sadness” rather than “illness”—and I continue to use a similar register throughout the remainder of this dissertation in an effort to legitimize non-medicalized descriptions of personal hardship.6 What is salient to my discussion of anti-psychiatry movements is, therefore, not the question of whether uncontrollable psychic pain, debilitating madness, and excruciating compulsions are real. They are real. What matters is the broader question of whether pain and madness are necessarily or always irrational, pathological, undesirable, or pharmacologically/biotechnologically remediable. Might “mental illness” experiences, howsoever brutal, have philosophical or pedagogical value to people enduring them? Might the forcible introduction of “mental health,” in turn, sometimes feel like a form of illness?

Regardless of my personal history, my anthropological training compels me to scrutinize the techniques by which hegemonic discourses achieve their appearance of naturalness and

6 To illustrate my concern, I offer the following example from a context familiar to most educators. A student who misses an exam and later submits to his professor a signed medical certificate labelling him with a psychiatric diagnosis may—or, in many institutions, must—be eligible for accommodations. Another student who misses an exam and verbally explains that he was “really sad” or “messed up” would likely be directed to campus health services, where he might receive a diagnosis and be accommodated on that basis. In general, the claim of being “sad” would not in itself entitle a student to special dispensation—nor do I argue that it necessarily should, given the potential for abuse. As a teaching assistant, I myself have on many occasions advised troubled students to seek professional guidance and/or insisted that they authenticate certain “excuses” with official documentation. However, we should ask ourselves about the unintended outcomes of privileging medicalized words and expert knowledge claims over vernacular ones. Whose interests are served, which ideologies are reinforced, and which marginalized, when these practices are repeated thousands of times a year in institutions across the continent?
normalness, and to unpack the ways such appearances serve certain interests at the expense of others. Being critical of our society’s knee-jerk “medicalizing impulse” (Furler et al. 2010: 235) is not, in my view, incompatible with robust anthropological work; indeed, it is arguably a prerequisite to it. At the same time, as my response to the woman at the bus shelter illustrates, I am not immune to that impulse. Like other middle-class people in this country, I benefit from the array of protective devices embedded throughout civil society that keep marginalized constituencies spatially and conceptually “away” from more privileged ones. Like other racialized individuals (Chinese, in my case) who speak English with native fluency, I benefit from a facility with the country’s lingua franca that allows me unproblematic access to services and resources, and that reinforces a perception of other racialized people as inadequately assimilated. Like other heterosexual, cisgendered people, I do not find myself caricatured, ridiculed, or pathologized every time I turn on the television or open a newspaper. And so, in the course of living my life, I am able to pass all sorts of subtle “checkups” that others cannot, and with a casualness that enhances others’ marginality. The epistemological and managerial regimes that sustain all of these privileges are implicated in, and imbricated into, what is conceived in this thesis as a “psychiatrizing” culture. By performing the precautionary act of moving away from the woman at the bus shelter, I became complicit in an ideological system that treats unanticipated displays of affect as symptomatic of danger. In short, the fact that I am critical of psychiatry and am, to some extent, a psychiatrized person does not mean that I—as someone who is generally able to “perform normalcy” on a daily basis—do not benefit from and contribute to the psychiatrization of others, however unwittingly (Brueggemann 2005: 20). Moreover, because I have never seen a psychiatrist, received an official diagnosis, been hospitalized, or taken psychiatric drugs, I do not position myself as having “insider” status in the psychiatric survivor/consumer/ex-patient community and I readily acknowledge that my experiences do not necessarily reflect those of other psychiatrized people.

3.3 Regarding Terminology

Throughout this dissertation, I use psychiatric terminology that has entered the lay lexicon (e.g. “diagnosis,” “patient,” “symptom”) even though their usage may appear to be inconsistent with a critical, constructivist understanding of psychiatry. These usages are, at times, mitigated with the use of quotation marks or other contextual devices, and I hope it is clear that I do not accept the conventional view of mental illnesses as well-defined disease entities that are localized within individuals’ brains. To foreground the fact that psychiatric terminologies are depoliticising
artifacts that conceal political histories, I always explicitly refer to a diagnosis as a diagnosis (“The doctor diagnosed him with depression,” “She was diagnosed with an anxiety disorder”). Whenever these tags are not present, I am referring not to diagnoses but to generic affective states (“He was depressed,” “She became anxious”).

As will be discussed in later chapters, criteria for membership in psychiatric survivor communities are mutable and contingent on many variables. For example, some individuals who self-identify as “psychiatric survivors” are not seen by their peers as authentic “survivors,” often because they lack certain genres of inpatient or outpatient experience (e.g. an official diagnosis, a hospital stay, or firsthand knowledge of how psychopharmaceutical compounds can impact volitional capacities). Likewise, many self-identified “psychiatric survivors” resent their inclusion in what some scholars and activists have called the “C/S/X” movement (“consumer/survivor/ex-patient,” see Estroff 2004, Morrison 2005), because the acronym’s usage of the forward slash symbol implies that the three constituencies are interchangeable or that their differences are negligible. In particular, people who feel that psychiatry has grievously harmed them do not necessarily wish to be lumped together with people who feel that psychiatry has helped them. As in every social movement community, debates about identity labels abound in anti-psychiatry. Because this dissertation understands psychiatry as a cultural, political, and ideological infrastructure that upholds wide-ranging eugenic discourses about desirable and undesirable bodies, I use the adjective “psychiatrized” to refer to anyone whose thoughts/habits are rendered pathological by the psychoscientific knowledge regimes that permeate civil society (Eghigian 2011). This term will include, for example, individuals whose eating disorders, self-injurious practices, “delusions,” or obsessive compulsions have never been officially diagnosed, but whose lives have nonetheless been heavily shaped by psychiatry’s epistemological authority. By striving for maximal inclusiveness, I aim to shed light on some of the inequities that can arise when boundaries around cherished identity labels are unyieldingly policed.

My use of the umbrella term “anti-psychiatry” in reference to a wide range of communities that mobilize against psychiatry follows standard practice among my informants, who consistently treated the word as an efficient, one-word synonym for multitudinous resistance paradigms (mad liberationism, the psychiatric inmates’ movement, psychiatric survivorship, etc). For example, one psychiatric survivor, with whom I regularly exchanged links to news articles about malpractice cases, lawsuits, inquests, and online essays critiquing the psychosciences, frequently began his emails with lines like, “More from the anti-psychiatry bureau” or “Anything new in anti-psychiatry these days?” Another informant, who had no
qualms with biochemical models of mental illness but is no longer able to work due to neurological damage from electroconvulsive therapy (ECT), currently spends her days trying to publicize her ordeal; she told me that she now considers “anti-psychiatry” her fulltime job. As Crossley (2006: 103) notes, scholarly debates about whether the label “anti-psychiatry” is or is not applicable to particular networks of activists elide the fact that fixed definitions rarely capture activists’ own fluctuating deployments of the word. When asked outright, some of my informants produced official definitions that invalidated the right of all but the ideologically “pure” to clothe themselves in the term (see also chapter 3). In isolation, the term would indeed seem to denote a specific, categorical agenda of abolishing all psychiatric technologies, vocabularies, and institutions, whatever that would entail. However, it is precisely because “anti-psychiatry” was, in unofficial contexts, used freely and polysemously by multiple actors in reference to far less absolutist agendas that I have elected a broader definition of the term. As will be seen, while alternative descriptors like “psychiatric survivor,” “psychiatric consumer,” “C/S/X,” and “Mad” may appear at first glance to be more ecumenical, none proved any less controversial or less rigorously policed during my time in the field.

The terminology that I use when discussing race is heavily informed by Weismantel’s (2001) insight that while the concept of race is a constructed fiction, its uptake in popular discourse has very real consequences; it is thus disingenuous to speak of race in anything less than candid terms while racism still exists. Accordingly, I employ the identifiers “white,” “non-white,” and “racialized group,” rather than euphemisms that smuggle in hierarchy (“visible minority”) or essentialism (“racial group”). I am aware, however, that these labels are politically problematic in their own ways, and, in deploying them, I do not meant to imply that I believe the “white” population of Toronto to be culturally, religiously or ethnically monolithic.

3.4 Transcription Conventions

Researchers have long argued that transcription is as much a craft as a technical procedure, and that transcripts are authorial productions with inevitable political effects (Davidson 2009, Tilley 2003, West 1996). Producing useful transcripts from audio-recordings requires analysts to make interpretive and representational choices that are laden with ideological presuppositions about, and predispositions toward, the subject matter—how/whether to transcribe accidental noises or paralinguistic cues, where/whether to use non-standard orthographies, and so on—and these choices tend to acquire an air of epistemic authority when presented on paper as the ‘empirical evidence’ from which conclusions organically arise. For the same reason, audio-recordings also
cannot be treated as atheoretical basins of data; as Ashmore et al. (2004: 351) observe, the very existence of an audio-recording implies a convergence of career trajectories and professional privileges that have given rise to “naturally occurring” linguistic interactions, and the fact that anthropologists tend to tape people when studying them incurs an observer’s paradox. Yet it would be both impossible and undesirable to try to efface these facts. Our goal, as Bucholtz (2000: 1461) points out, “should not be neutrality but responsibility.”

In light of these cautions, I will be make using of two types of transcription schema in the pages that follow. In instances when the focus of my analysis is the content and structure of a spoken narrative or a portion of a narrative produced by a single individual, I employ “literacized” transcription, in which the text assumes the conventions of written discourse (Bucholtz 2000: 1461). Lengthy extracts from these narratives will be presented as block quotations, organized with punctuation marks and paragraphing, and edited to omit backchannels and non-lexical hesitation markers (“uh,” “um,” “er”). False starts and repairs will be retained in instances where they are analytically revealing or where their removal decontextualizes subsequent statements. While transcripts of this type run the risk of eliding the subtleties of oral speech, my rationale here is twofold. First, this technique helps to foreground narrators’ deployment of rhetorical strategies above the level of the morpheme (e.g. lexical and semantic choices, orientational metaphors). Second, by eschewing transcription methods that are unnecessarily defamiliarizing, I hope to avoid portraying speakers who have been diagnosed with psychiatric disorders as incoherent or less-than-articulate, especially when their reasoning often turns out to be quite eloquent (cf. Jefferson 1996 on “transcriptional stereotyping”).

In instances when the focus of my analysis is an interaction between multiple interlocutors in which speakers’ interruptions of and contributions to an evolving dialogue take centre stage (e.g. in the context of a meeting or social gathering), I employ a less literacized method of transcription that is more faithful to the flavour of oral speech and that, to this end, includes backchannels and non-lexical hesitation markers. In such instances, the conventions employed are as follows:

- .
- ,
- ?
- 
- (Leigh taps her head)
- (indecipherable)
- No, [it’s over] here, right?
- He said [Ryan: No way] he would
- just forget it
- She was like ‘oh yeah’

end of intonation unit, with falling intonation
end of intonation unit, with fall-rise intonation
end of intonation unit with rising intonation
interruption or self-correction
analyst’s insertion of paralinguistic information
indecipherable speech
insertion of words for semantic or contextual clarity
speaker’s turn contained within another speaker’s turn
italics indicate emphatic stress or increased volume
single quotation marks indicate quoted speech
In order to avoid imposing an unnecessarily exotic aura upon these linguistic productions, I will not be transcribing at the phonetic level when interlocutors speak with a “foreign” accent, so as not to portray systematic differences in pronunciation as deviations from a canonical standard (O’Connell and Kowal 2009: 242). My goal is to maintain the semantic and syntactic intelligibility of these conversations without introducing a distracting level of description for description’s sake.
Chapter 2
Setting the Scene: Methodologies and Modes of Inquiry

1. Locating the Field

1.1 Geographic/Biographic Boundaries

My methodological approach has evolved out of Marilyn Strathern’s (1996) insight that human and non-human agents, objects, and events are bound together through relations of skill and labour that allow some the possibility of ownership and exclude some others. The social networks that allow technoscientific innovations to take place, for example, are not all encapsulated within the patents that issue from them. When the virus that causes Hepatitis C was isolated, the patent attorney for the company that developed the diagnostic test argued, “We don’t claim we did all the research, but we did the research that solved the problem” (*The Independent*, December 1st 1994, quoted in Strathern 2006 [1996]: 485). This logic severs the wide-ranging configurations of knowledge, privilege, collaboration and imagination that make scientific research possible, and prunes off a fragment to which credit can be neatly assigned. But, of course, this is not the only logical tack available to those vying for inclusion.

The underlying question is: what criteria should we use, in a given circumstance, to identify the principal acts and actors in a given enterprise, so that we can “cut the network” at an appropriate place, while remaining sensitive to the exclusions we foster? Marcus’s (1995: 105) call for multi-sited methods “in which the ethnographer establishes some form of literal, physical presence with an explicit posited logic of association or connection among sites that in fact drives the argument of the ethnography” is salient here (see also Rajan 2006). To flesh out an ethnography of resistance practices, I follow a growing tradition in anthropology that grounds analyses not in a spatially defined community, but rather in the communicative and cultural resources that individuals mobilize to carve out a community (Glick Schiller and Fouron 2001, Hage 2005, Kelsky 2001). During my fieldwork, therefore, while I tried to cast a wide net, I eventually became especially attuned to explicit and implicit expressions of *belonging* and *alienation*, and it is around this tension—as manifested in archival data, news reports, life narratives, and social interactions—that this study is structured. I listened carefully when infuriated people gave me advice like, “Never try to be something you’re not, it’ll always bite

---

7 My notebooks and audio files are bursting with data on my informants’ views on local and international politics, other social movements in which they participate, neighbourhood gossip, grievances about school and work, and much more, all of which are analytically revealing in their own ways—and all of which have enriched my understanding of the texture of their lives—but only some of which are germane to this study.
you in the ass, always.” I paid close attention to how psychiatric survivors joked about “sane” people, and how non-survivors attempted to downplay their ascribed “sanity.” I took detailed notes about the ways in which people despaired over their liminality (“If you’re not mad, you must be normal? It’s so dumb”) as well as the ways in which people casually dismissed others’ claims to membership within certain constituencies (“Sorry, but no. You are not a survivor,” “He’s a critic of psychiatry, but he’s not anti-psychiatry”). I noted, too, the rhetorical techniques through which the mass media disentitled the “mentally ill” from full membership in the national body politic by conferring the bonds of belonging upon some citizens while stripping them from certain others. And I was struck by how often people’s stories seemed to conclude on a high note (e.g. with their discovery of the psychiatric survivor and/or anti-psychiatry movements) and how the frustrations they experienced within these movements seemed to belie those happy endings. These are the voices and efforts, both verbal and material, to which the remainder of this dissertation attends, with an eye to destabilizing the “artificial disciplinary history that left social science concerned with that aspect of society that transcended its composition by individuals and ceded to psychology the study of the individual” (Miller 2009: 3).

My fieldwork spanned fourteen consecutive months from August 2009 through the end of September 2010 and was concentrated in suburban York Region and urban Toronto. The data that forms the core of this study derives primarily from my participant-observation in three grassroots groups that met regularly and followed an ethos that was strongly critical of mainstream psychiatry, each of which is described in more detail in section 2 below; many hours of in-depth, open-ended interviews conducted with both individuals and groups; many more hours of casual conversation and impromptu socialization in kitchens, coffeehouses, streetcars, subway trains, restaurants, basements, at potluck dinners, birthday parties, political rallies, and film screenings, and on long walks through the city; and an intensive effort at dialoguing with former participants in anti-psychiatry initiatives in both Canada and the United States, which involved both electronic correspondence and archival research that was greatly facilitated by the Psychiatric Survivor Archives of Toronto. In addition, I document some key conflicts and concerns expressed by some of my informants in the weeks leading up to a major international conference of psychiatric survivors organized by an anti-psychiatry activist organization based in the downtown core (“PsychOut: A Conference for Organizing Resistance Against Psychiatry,” May 7th - 8th 2010; hereafter referred to as “PsychOut”).

In total, approximately seventy people throughout the Greater Toronto Area participated in my research, most of whom were recruited through snowballing procedures (e.g. word of
mouth, listserv announcements, friends of friends). Eleven people in the United States also participated by email, generously engaging in many weeks of written correspondence (see chapter 3). Some of my most helpful informants assented to being interviewed but declined to be recorded, initially citing privacy concerns, but later revealing that they had been audio-taped in psychiatric wards and understandably did not wish to duplicate the experience; in these instances, I tried my best to take detailed and careful notes during and after each interview. In all, I recorded approximately 190 hours of talk and/or interaction, with individual interviews lasting from one to three hours. My informants ranged in age, literally, from eighteen to eighty—one reached his eighteenth birthday in the middle of my fieldwork and, having reached the age of majority, decided that he wanted to participate; and another reached his eightieth birthday just as my time in the field drew to a close. As will become clear later, while my informants’ socioeconomic class and professional backgrounds vary quite considerably, there are clear correlations between their age, geographic place of residence, income levels, income sources, and the types of critiques they develop about psychiatry.

During my fieldwork period, interactions and conversations within these social networks were heavily influenced by three sets of debates that permeated local, provincial, and international mental health advocacy circles. First, consultative work on the newest edition of the DSM (“DSM-5”) was drawing to a close: for the first time in fifteen years, key diagnostic criteria were being dramatically reconstituted, new disease constructs were in development, and a radical revision in the conceptualization of “risk” was in the works. This was seen as a major opportunity as well as a major threat by psychiatric survivors, mental health advocates, clinicians and physicians who were critical of the DSM-IV, family members of patients, and many other constituencies, such as the transgender and neurodiversity communities. Second, a number of high-profile murders, violent crimes, and criminal trials that have taken place in recent years, in which forensic psychiatrists played significant roles (especially school shootings and filicides, see chapter 7), formed the grist of countless kitchen-table conversations about the multidimensional nature of volition, and revealed key insights about the criteria that people use to distinguish between what is and is not within a person’s conscious ability to control. Finally, the relentless refrain that mental illness is taking a “massive toll” on the national economy, which was repeated loudly and frequently in the local and national news media during my fieldwork year, was another recurrent source of discussion and debate, the ideological dynamics

---

8 The quote is from the Toronto Star, which reports that “Mental illness costs the Canadian economy about $33 billion each year—about 2.1 per cent of GDP—in absenteeism and lost productivity” (Yew 2009a: B1).
of which I discuss in chapter 4. The principles that shaped my selection and collection of mass media texts for analysis, and their rationales, will also be explicated in chapter 4.

1.2 Mental Healthcare in Ontario: Infrastructure and Oversight

Before introducing my informants, a thumbnail sketch of the Ontario healthcare system is in order. With the main exception of participants over the age of fifty, whose lives have included more job changes and more places of residence, the majority of the psychiatric survivors whom I interviewed grew up and encountered psychiatry in this province. Because healthcare and insurance coverage operate differently in Canada than in the United States, where most anthropological studies of psychiatric consumers have been conducted (e.g. Estroff 1992, Luhrmann 2001, Coleman 2008), it is necessary to offer a brief overview of certain conventions and terminologies. An annotated glossary of abbreviations used in this dissertation is also included in Appendix III.

While publicly funded healthcare has existed in varying forms throughout Canada since 1946, it was not until the passage of the Canada Health Act in 1984 that all Canadian provinces were obliged to run universal health insurance plans in order to qualify for federal transfer payments (see Fierlbeck 2011). In Ontario, this plan is called the Ontario Health Insurance Plan (OHIP) and is automatically available to all Canadian citizens, permanent residents, and work visa holders whose primary and permanent dwelling is in this province. Under OHIP, general practitioners and hospitals bill the province for services rendered to OHIP cardholders, who are thus able to access preventive and emergency healthcare free of charge. However, private health insurance continues to play a major role in provincial reimbursement systems, as OHIP does not cover many frequently accessed services, such as dental care, prescription drugs, adult eye examinations, hearing aid tests, outpatient physiotherapy, ocular and mobility devices, nutritional supplements, and complementary/alternative healthcare. The fact that OHIP covers none of these services but does cover electroconvulsive therapy (ECT) has been a longstanding grievance of psychiatric survivors in Ontario. Because ECT can result in permanent memory loss and cognitive deficits (see Andre 2009, Burstow 2006a and 2006b), many survivors argue that it is inappropriate for taxpayers to fund such a controversial procedure when so many other services that are crucial to their overall “mental health” are not currently funded.

OHIP cardholders who spend more than 4% of their net annual household income on certain prescription drugs are eligible for a public drug insurance plan called the Trillium Drug Program, and individuals with certain disabilities are also eligible for drug coverage under the
Ontario Disability Support Program (ODSP). ODSP is an income support program administered by the provincial Ministry of Community and Social Services, which is available to adult residents of Ontario with a qualifying mental or physical disability, as defined in the Ontario Disability Support Program Act. The monthly financial supplement that is available to an eligible applicant is dependent on his or her family size, income, assets, and housing costs (Ontario Ministry of Community and Social Services 2012: para. 3). ODSP also covers certain other healthcare expenses, such as dental services, diabetic supplies, and prescription drugs that are listed in the Ontario Drug Benefit formulary. It is common, but not inevitable, for psychiatric survivors to make use short- or long-term use of ODSP following a hospital stay, often due to its interruption of their employment status or due to other difficulties associated with their psychiatrization. As several of my informants pointed out, and as more implicitly demonstrated by events in other informants’ lives, ODSP legitimizes a narrow conception of “mental health” in that it covers psychiatric drugs but makes no provisions for other factors that are integral to recovery from existential challenges (e.g. access to education and information, participation in political discourse, meaningful involvement in a community, see chapters 6 and 7).

The administration of voluntary and involuntary admissions into psychiatric units is regulated by the Ontario Mental Health Act (OMHA). Under the OMHA, police officers may take anyone into custody for examination at a psychiatric facility, as long as they have “reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner” and may be a threat to themselves or another person (Government of Ontario, Mental Health Act, 2010: sections 17-18). Police officers do not need to have personally witnessed the disorderly behaviour in question and have the discretionary authority to detain people solely on the word of third parties. Physicians also have the discretionary authority to “change the status of an informal or voluntary patient to that of an involuntary patient” at any time, if they are “of the opinion that the patient… is not suitable for admission or continuation as an informal or voluntary patient” (sections 19-20). Patients’ rights under the OMHA are quite limited. Although patients are theoretically entitled to refuse treatment, this right is not extended to patients who are declared “incapable” by a psychiatrist, which may also occur at any time. Individuals who are committed by physicians for involuntary stays of over two weeks are entitled to appeal the decision to a “Consent and Capacity Board,” but such boards are not required to consider the input of current or former psychiatric patients; they are required only to include a lawyer, a psychiatrist, and a member of the community (section 39). Patients who disagree with the decisions of Consent and Capacity Boards may appeal to the Ontario Superior Court of Justice.
(section 48). Since the passage of Bill 68 in December 2000, the OMHA also authorizes physicians to put psychiatric outpatients on Community Treatment Orders (CTOs), a legal mechanism that is better known in the United States and elsewhere as Involuntary Outpatient Commitment (IOC). Under a CTO, outpatients are required to take medication or be forcibly hospitalized. CTOs last six months and are indefinitely renewable (section 33), although subjects can appeal to a Consent and Capacity Board. Psychiatric survivors throughout the West have objected to IOC-style laws on several grounds: they unjustly assume that psychiatrized people are predisposed to violence, they oblige outpatients to ingest chemicals that cause them ill effects, and they disproportionately target the poor.

In Ontario, the practice of medicine is regulated by the College of Physicians and Surgeons of Ontario (CPSO). Membership in the CPSO is mandatory for all licensed doctors who wish to offer medical services in the province, and the organization’s duties include certifying and registering doctors, monitoring standards of practice, investigating malpractice complaints, and disciplining members who have engaged in professional misconduct (College of Physicians and Surgeons of Ontario N.d.: para. 2-6). A key criterion in the adjudication of malpractice complaints is the question of whether the “standard of care” was maintained in particular cases. Under Canadian tort law, the “standard of care” refers to the course of action and level of prudence that can reasonably be expected of a physician in a given situation (Caulfield and Feasby 2001: 199). If a doctor’s treatment of a patient was consistent with the pattern of action that other doctors would have undertaken in similar circumstances, the applicable “standard of care” has not been violated and the doctor would not be found negligent. This criterion has made it difficult for psychiatric survivors and their family members to file successful complaints with the CPSO, as their psychiatrists’ conduct may not have deviated appreciably from the accepted professional standard, as determined by their peers. At the time of this writing, at least two of my informants have complaints pending with the CPSO.

2. The Study Population

In the paragraphs below, I introduce readers to the three groups with which I spent most of my time. To avoid jeopardizing participants’ anonymity, I have changed all personal names, excluded or masked sensitive biographical details, and employed pseudonyms in place of these

---

9 This type of legal mechanism was introduced in many Western nations following the widespread deinstitutionalization of mental healthcare in the 1980s. Chapter 3 discusses the social and political history of these events in more detail.
groups’ actual names throughout this work. This section does not contain exhaustive
descriptions of all of the individuals or groups that I encountered, interviewed, and spent time
with while in the field—indeed, very far from it. It does, however, establish some of the key
players in the conversations and events that unfolded over the course of 2009 and 2010, and sets
up a point of narrative departure for the chapters to come. To facilitate cross-referencing, I
provide in sections 2.1, 2.2, and 2.3 the names I have assigned to these key players, whom we
will get to know in greater depth later in this study. Each name is identified beneath the group
she or he was primarily associated with during my time in the field. Individuals who were
associated with more than one of these groups are identified with the one through which we first
met (e.g. Yashar, whom I first got to know through the Unhinged peer support group, and whom
I later encountered at an Acceptance meeting; or MacDaniel, who was associated primarily with
Unhinged, but was also acquainted with Benjamin and Cassidy of Folie à Deux and Sylvie of
Acceptance). Individuals who are mentioned in this thesis, but who were not members of any of
the groups I studied, are parenthetically indicated next to the name of the person with whom their
story is most connected (e.g. parents Helen, Armaghan, Elias, and their children, Matt, Magda,
and Winston). Only one interviewee, an ECT survivor whom I call Vanessa (chapter 5), was
neither directly nor indirectly affiliated with any of the below three groups; I met her by chance
through another organization unrelated to my fieldwork.

I spent my days in the field inhabiting two very different roles: that of the ethnographic
observer, whose frenetic handwriting style was a source of considerable amusement for
onlookers, and that of the regular attendee, who sat around the same table as everyone else,
sharing opinions, contributing snacks (a controversial feature of these gatherings, to be discussed
in later chapters), griping about current events, partaking in creative writing projects, and
participating in regular “go-arounds” during which we were often expected to produce succinct
narratives about how we felt that week, why we felt that way, what kinds of challenges we
were currently confronting, how we were addressing them, and so on. We became accustomed to
reintroducing ourselves to each other, over and over, for the benefit of visitors and newcomers

---

10 It is common for grassroots social movement groups to have only a few core members, which is what allows them
to convene on a regular basis in living rooms, basements, and kitchens. Crossley (2006) discovered this as well in
the course of his own study of anti-psychiatry organizers in the United Kingdom, as some of the groups he studied
consisted of only two or three members. Revealing the actual names of such groups can therefore threaten the
privacy—and betray the confidences—of members whose involvement in an ethnographic study has arisen from an
expectation of anonymity (see also Hopkins 1993). I have attempted to pick pseudonyms that reflect a key element
of each group’s real name, however. For example, “Unhinged,” the arts therapy group, did in fact use a name that
was originally designed to poke fun at mainstream stigmatizations of psychiatric survivors, but that, later on, was
interpreted as offensive by newcomers who hadn’t participated in the original “naming” event.
who sometimes happened to join us on particular day—friends who had given a ride to a regular attendee, or attendees’ children or partners. We, in fact, participated in so many rounds of introduction and reintroduction that most regulars instinctively issued a standard blurb (“I’m Ashley. I’m a psych survivor and an activist”) or a standard in-joke (“I’m Nate, and I’m just a groovy guy”). I took to describing myself in a dry, tongue-in-cheek way (“I’m Eugenia. I’m the anthropologist. I’m spying on everyone”), which was often enough to send some of the regulars into fits of giggles and elicit mock outrage from others who insisted that I secretly worked for a pharmaceutical company.

2.1 Folie à Deux: An Anti-Psychiatry Reading Group

The group that I call Folie à Deux was essentially a book club, where readings were selected on the basis of their relevance to one of three topics—anti-psychiatry, euthanasia, or dystopian science fiction—all of which encompassed a central theme of self-ownership as an inalienable right. All eight of the group’s regular participants were residents of the affluent, suburban neighbourhoods of Vaughan, Markham, Richmond Hill and Aurora (municipalities of York Region, located just north of the City of Toronto; see Appendix I for a map), and most were white, native speakers of English, between the ages of forty and seventy. Their children and family members, some of whom I met and interviewed, also tended to reside in suburban areas throughout southern Ontario such as Oshawa and Whitby, although some also lived and worked in downtown Toronto. Meetings were held two or three times a month, usually at the home of the married cofounders, Ana and Alé. The reading list’s content and schedule were collectively decided every few months, giving members time to locate, buy, borrow, share, photocopy, and read the chosen texts, or announce in advance that they would be opting out of a particular week or month. Selections during my fieldwork year included writings by the surgeon and New Yorker columnist Atul Gawande, short stories from Isaac Asimov anthologies, a suicide instructional manual, and an essay from Phoenix Rising, a Canadian anti-psychiatry magazine that ran from 1980 to 1990 to which Alé once subscribed. At the behest of the group’s youngest participant, Julian—the eighteen year-old son of another member, Sheila—the “syllabus” also included films. Julian’s continual efforts to have the group embrace graphic novels were less successful.

11 Although the groups that I call Folie à Deux and Acceptance still exist and meet regularly, I use the past tense when describing them because my observations of them are necessarily anchored in a particular window of time.

12 The reading list tended to be dominated by white male authors, but, to be fair, this is true of most reading lists. See chapter 3 for more on Phoenix Rising.
Due perhaps to the age difference that set me apart from the other regulars (except Julian, who attended only irregularly), participants tended to treat me like a kid who was working on a school project. Despite my constant assurances that I was eating enough, Ana—an American expatriate in her sixties—regularly needled me about being underfed, and I would occasionally arrive at her home to find that she had just prepared a pan of peanut butter squares that she would then, to my chagrin, urge me to consume. She had a withering intellect, was widely read, and cheerfully rejoined each of my questions with provocative questions of her own. When, to my surprise, someone mailed me a DVD called “Making a Killing: The Untold Story of Psychotropic Drugging,” it was Ana who instantly (and correctly, see Rissmiller and Rissmiller 2006) identified the Church of Scientology as a chief source of funding for the filmmakers, an advocacy group called the Citizens Commission on Human Rights. Despite the fact that psychiatric survivors are routinely obliged to disprove any association with Scientology and, for this reason, typically avoid the religion’s materials (see Crossley 2006: 134-135; Brean 2010 contains one example of this allegation), Ana, as a self-described libertarian socialist, thought it important to give their point of view “a fair hearing.” She made it the first point of business that week to put their DVD on the “syllabus.”

The atmosphere during meetings was quite casual, and, within half an hour, conversations would almost invariably and sometimes irreversibly veer away from the assigned texts. As a student, I was accustomed to doing readings on a regular basis, and, at first, I tried my best to carefully work my way through each text, taking detailed notes that I thought might come in handy at meetings. However, I began to pay less attention to the readings and more to the readers when I realized that the “book club” identity functioned as a sort of foil that allowed this network of mostly professional, materially successful people to clothe their heterodox attitudes toward psychiatry in conventional garb. Three members, as I gradually learned, had had harrowing and humiliating experiences within the psychiatric system—involuntary hospitalization lasting months, forcible medication or ECT—and all maintained that their 13 There are four intersecting reasons why survivors feel they must do this. Scientology has in recent years attracted considerable media attention for its vocal opposition to psychopharmaceuticals and for the testimonies of former members who call the organization an abusive and highly litigious “cult” (Cowan and Bromley 2008, Köhler 2012, Kumar 1997, Reitman 2006). In the meantime, the mainstream media overwhelmingly portray modern biological psychiatry as scientifically robust and morally enlightened (see chapters 4 through 6). Thus, non-psychiatrized observers can find it hard to understand—and have limited access to stories that contextualize—how anyone could possibly oppose modern psychiatry if not under the orders of a famous “cult.” Many psychiatric survivors therefore see it as vital to clarify, in no uncertain terms, that their motivations are independent of Scientology’s. Because my fieldwork did not involve an ethnographic focus on Scientologists, a full and fair investigation of the religion’s anti-psychiatric politics is beyond the scope of this project.
involvement in an “anti-psychiatry” reading group had little to do with those experiences, and more to do with a desire, as Sheila put it, to “get off my duff and do something cerebral.”

Key players included: Ana, Alé, Benjamin, Cassidy, Gracie, Julian, Leigh, Malcolm, and Sheila. All of them were white and had grown up in Canada, except for Ana and Alé, who were white Latinos originally from California; they had moved to Canada in the 1980s on the basis of Ana’s Canadian parentage and dual citizenship. Benjamin, Malcolm, and Alé were retired and had worked in professional industries requiring a level of tertiary education. Cassidy and Sheila worked fulltime in the public sector, and Leigh was a homemaker whose husband worked at an engineering firm. The only Folie à Deux member who was not firmly in the middle class was Gracie, an ODSP recipient who earned money informally by teaching beginners’ guitar classes, cleaning, and performing other household services that she advertised on community bulletin boards. Ana had been one of her clients; they had learned of each others’ respective anti-psychiatric orientations and past involvement in mad liberationist activism during a conversation in 2009, and Ana invited her to join the reading group on the spot. As the sole member of limited financial means, Gracie was driven to the biweekly meetings by either Ana or Leigh.

2.2 Acceptance: A Family Support Group

This was a support group for family members of psychiatric outpatients, and a striking example of the increasing popularity of the consumer/service-provider model to constituencies affected by psychiatry, which promotes patients’ rights by playing up the observation that psychiatry is an industry, and, like any other industry, is answerable to its paying clients (Torrey 2006). Based on their loved ones’ experiences with mainstream psychiatry, participants had developed serious grievances about the psychiatric system, which Jared—a graduate student in his thirties whose fiancée suffered from panic attacks and social anxiety—described as ineffective, condescending, “mercenary,” and “more about pills than people.” With the sole exception of Jared, all of the regular participants during my fieldwork period were parents of teenagers and young adults who had been diagnosed with mood disorders, eating disorders, and, in the case of one couple’s seventeen year-old daughter, a depersonalization disorder. There were typically more mothers than fathers present at meetings. Meetings were held at biweekly intervals on weekday evenings, with breaks in August and December, and usually took place in rooms booked at community centres or public libraries throughout the former municipalities of North York, Etobicoke, and Scarborough (neighbourhoods in the northern half of the City of Toronto). Helen, Risa, and
Keane, the group’s cofounders, took turns reserving these rooms and reminding the other participants of each meeting’s date, time, and location by email, typically one week in advance.

The stories that parents of psychiatrized children shared with me and with each other were poignant and often very sad. Esther, a single mother and South Korean émigré, frequently asserted that she was at her “wits’ end.” Her son had been diagnosed with depression as a teenager and now, in his twenties, spent all of his time on the computer or watching television. No matter what treatments he tried or how she pleaded, she could not “get him” to do anything else. His diagnosis seemed to worsen his affective state: as Esther routinely pointed out, he now had a medically sanctioned “excuse” for his behaviour. She worried, intensely, that if anything ever happened to her, he would wind up homeless and unable to support himself. Other parents in the group had strikingly similar stories, the underlying thread of which seemed to be: psychiatry doesn’t do its job. When they had turned to psychiatry for solutions to their children’s delinquency or distress, they did so with a visceral mixture of hope and resentment toward the medications, recommendations, and unsolicited criticisms that constituted the treatment plan. They felt that they had abdicated a great deal of emotional and moral authority when deferring to psychiatrists’ judgements; they felt badly betrayed when the prescribed treatments failed to help their children and sometimes even harmed them; and, above all, they felt guilty.

Key players included: Armaghan (Magda), Elias (Winston), Esther, Jared (Deirdre), Helen (Matt), Keane, Risa, and Sylvie. Of the three groups I worked with, this one was the most racially and ethnically diverse. Armaghan and her husband had immigrated to Canada from Iran in the 1980s, and Magda had been born in Montreal. Esther and her late husband had immigrated to Canada from South Korea in the 1990s, and her son had been born in Toronto. Helen, Matt, Elias, Winston, Risa, and Keane were white Canadians. Jared was a Jewish Canadian of Russian descent, and his fiancée Deirdre was a white Canadian. Sylvie was a white Canadian who had attended high school and college in the United States, and worked in an administrative capacity for a postsecondary educational institution. Armaghan worked fulltime in the retail sector, Elias worked fulltime in marketing consultancy, Helen worked on a contingent basis for a major media outlet, Jared (aside from his graduate studies) worked as a private tutor and occasional street busker, Esther was a technical labourer in the healthcare sector, and Winston worked in the backroom of a supermarket. Deirdre, who had just concluded a stint on ODSP when I first met her, worked part-time for a charitable organization. Risa and Keane were the joint owners and operators of an independent consulting business.
2.3 Unhinged: An Arts Therapy and Peer Support Group

The group that I call Unhinged was a loose network of psychiatric survivors, anti-poverty and antiwar activists, and proponents of alternative therapy who met between two and six times a month, formally and informally, to provide peer counselling to each other and work on artistic projects. These artistic projects were usually personal writing projects of various kinds: poetry collections, zines, screenplays, and journals. All of the members were young adults, ranging in age from nineteen to the early thirties (although one, Richter, was in his forties); some were unemployed, and even those who were employed could only live “paycheque to paycheque.”

Women and men were more or less equally represented. Like Folie à Deux, the group was predominantly white. Almost all of the members identified as radicals, anarchists, Marxists, or “lefties” in a broad sense, with the exception of Ivy—who, as a non-white (Chinese) person of fairly substantial monetary means and a resident of suburban Richmond Hill, was an exception in many ways.

Unhinged originated in 2006 when its two founders, Ryan and MacDaniel, realized that they had always found creative activity and “having someone to talk to” more therapeutic than any form of somatic treatment. The group typically met in members’ apartments, or at rooms booked at community centres or public libraries in downtown Toronto. Like most such groups, there was a fairly high turnover rate of attendees: friends of members would turn up for several meetings, and then vanish forever, and others would resurface after months of absence. It was explicitly pitched as an anti-psychiatry group, although not all participants were wholly comfortable with the “anti-psychiatry” framework. Many had had abusive experiences within the psychiatric system, but, even so, felt that there were branches of mainstream psychiatry that served as refuges of last resort for the urban poor, and these members maintained a tactical distinction between their absolute revulsion for institutions such as the Centre for Addiction and Mental Health (CAMH, one of Canada’s largest psychiatric institutions, whose main facilities are located in downtown Toronto) and their tolerance of the scattered nurses and activist-doctors whom they identified as acceptable “reformers.” Debates over what kinds of experiences a person minimally had to have endured in order to qualify as a psychiatric survivor were endless during my fieldwork year. In addition, it slowly became clear that certain participants harboured genuine antipathy for each other. Ivy, in particular, was a frequent target of Ryan’s ire. These antipathies came to a head in the weeks leading up to PsychOut, resulting, ultimately, in the group’s dissolution. I examine these events in detail, along with their wider political implications, in chapter 7.
Key players included: Alyssa, Ashley, Fleming, Ivy, Melinda, Olivia, Nathan, Pascal, Richter, Ryan (MacDaniel), Renée, and Yashar. All were white Canadians, except for Ivy, a Chinese Canadian who had immigrated from Hong Kong at the age of eight, and Yashar, an Arab Canadian of Egyptian descent who had been born in Toronto. With the exception of Ivy, the Unhinged psychiatric survivors occupied a far more marginal socioeconomic niche than their counterparts in Folie à Deux and Acceptance. Most had encountered psychiatry as teenagers or young adults and saw these encounters as having had, in various ways, determining or derailing effects on their subsequent life trajectories. Neither Alyssa nor Ivy had ever seen a psychiatrist or been officially diagnosed; however the two were not treated in the same way by their peers. Alyssa, who had suffered from depression, self-injury, and anorexia, always emphatically identified as an “ally” to the group—rather than attempting to claim inclusion as a bona fide “psychiatric survivor”—and, as a result, she endured no identity policing from the others. In contrast, Ivy, who had suffered from anorexia and obsessive compulsions, insisted that she was a “psychiatric survivor” and was eventually subjected to the others’ fastidious efforts (chiefly Ryan’s) to problematize this claim. Olivia and Ryan worked part-time in retail, Alyssa worked fulltime in the hotel industry, Renée was a freelance photographer and model who worked contingently in the alternative fashion industry, Pascal worked part-time for a private security firm, Yashar washed glassware at a private medical laboratory, and Ashley, Fleming, and Richter were on social assistance. I knew little about Melinda’s current life, but learned that she had previously worked in entry-level positions in the retail and restaurant industries (chapter 5). Ivy was a fulltime student who received a monthly allowance from her parents, who lived in Hong Kong and ran a successful business there. MacDaniel, who had left Unhinged two years before my arrival but continued to maintain a close friendship with Ryan and Olivia, worked fulltime as a library technician. Several Unhinged members were studying part-time for certification in trades such as hairstyling, culinary work, accounting and finance, and had substantial student loans. One was a part-time undergraduate student at the University of Toronto.

3. On the Author’s Access to Primary Historical Sources

My efforts to reconstruct the history of North American anti-psychiatry have relied heavily on primary source material contained in long defunct periodicals, as well as on discussions with some of their former readers and contributors; a brief explanation of my access to these sources is in order. While awaiting clearance from the Office of Research Ethics to proceed with fieldwork in the summer of 2009, I wrote three essays for the online edition of Counterpunch, a
leftwing political newsletter based in the United States. During my correspondence with Alexander Cockburn, *Counterpunch*’s founding co-editor, the topic of my dissertation arose and he invited me to contribute a piece to the newsletter’s print edition.\textsuperscript{14} I duly wrote and submitted an essay about the rise of DSM psychiatry and our society’s tendency to pathologize feelings of exhaustion and alienation. Due to the strict word limit, the final outcome included far less historical context than I would have preferred. Nonetheless, the short piece evidently resonated with many readers and, in the days following its publication, my inbox was inundated with hundreds of emails. Many of these emails were from self-identified psychiatric survivors who, completely unprompted, sent me lengthy recollections of their maltreatment in hospital wards and their horrifying experiences with psychiatric drugs. Despite the fact that my critique had focused on the *medicalization* of difference and not the *medication* of difference, the common theme of these emails was authors’ anger and disgust at their drugs’ debilitating side effects.

A small percentage of the people who wrote to me during this interval had been involved in the early anti-psychiatry communities, and their emails brimmed with nostalgia at their movement’s heyday and regret at the infighting that had led to its demise. Again with no prompting from me whatsoever, two former activists in the United States generously offered to mail me copies of publications to which they had contributed decades ago, on the rationale that these texts would otherwise just end up “sitting there, collecting dust.” Gary Novak, a subscriber and occasional contributor to *Madness Network News* (an American anti-psychiatry newspaper published from 1972 through 1986), sent me a thick bundle of issues dating from 1978 through 1986, including the last issue ever published. Robert Roth, co-editor of the *Madness Network News Reader* (a bound compilation of essays and poems from the first two years of MNN’s existence, published in 1974), sent me a rare remaining copy of the Reader. My unreserved gratitude goes to both Gary and Robert for entrusting irreplaceable historical texts into my care, without which my next chapter could not have been written. Eleven other Americans and two Canadians who had read my *Counterpunch* essay and who had participated in anti-psychiatry’s early iterations maintained an ongoing dialogue with me over the next few months, during which they patiently answered my many questions and explicated on the political trajectories of diverse forms of psychiatric survivor activism. One of my Canadian correspondents lived in nearby Durham Region and had once been a devoted reader of *Phoenix Rising* (whose creation had been

\textsuperscript{14} Alexander had a special interest in this subject. In the 1990s, he had co-authored (with former *Scientific American* editor Fred Gardner) an investigative report for the *Los Angeles Times* on the problematic marketing practices of pharmaceutical giant Eli Lilly, particularly in relation to its then-bestselling antidepressant Prozac. The *L.A. Times* decided not to print the story to avoid litigation.
inspired by the *Madness Network News*, see chapter 3). Over coffee, she reminisced about prominent personalities in the local psychiatric survivor community and their fraught relationships with other progressive political leaders. It was she who directed me toward the feminist newsmagazine *Off Our Backs* and its coverage of socially unequal dynamics at the 6th Annual Conference on Human Rights and Psychiatric Oppression, discussed in the next chapter.

The marginality of primary materials produced by psychiatric survivor activists is poignantly illustrated by the longstanding inability of the Psychiatric Survivor Archives of Toronto (PSAT) to secure affordable space for its extensive holdings. Founded in 2001, PSAT is one of the only archives in the world devoted solely to preserving materials created by individuals who have experienced the psychiatric system. Throughout its entire existence, PSAT has been, for financial reasons, unable to open a reading room for researchers or to make materials available for public perusal. Its holdings are currently kept in a publicly inaccessible storage locker in the basement of the Gerstein Crisis Centre in downtown Toronto. My access to back issues of *Phoenix Rising* was nonetheless made possible after the PSAT Board hired a pair of archival assistants to digitize the entire *Phoenix* collection, hard copies of which had been donated by *Phoenix* founding editor Don Weitz. The digitization process was completed in late 2009, which fortuitously coincided with my entrée into the field. In late 2010, the digitized collection was made available online. PSAT’s diligent stewardship of the city’s psychiatric survivor historiography was what enabled my eventual access to *Phoenix Rising*, but it was Alé, Ana, and Malcolm of Folie à Deux who first alerted me to the magazine’s historical significance and who first showed me their dog-eared *Phoenix* clippings, and I thank them for this. I also thank Geoff Reaume of PSAT, who kindly gifted me a partial photocopy of an issue of *Mad Lib*, the Washington D.C. mad liberationist newspaper quoted later in this chapter; and Benjamin of Folie à Deux, who generously lent me his copy of *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (Chamberlin 1978).

The texts named above are only partially representative of the history of organized resistance against psychiatry; their relative prominence has increased the probability of their preservation in private and institutional collections, while more marginal publications with shorter lifespans have, in many cases, vanished for good. This is true of both primary and secondary historical materials. All of the secondary accounts from which I draw in this chapter are available in scholarly libraries, with the exception of two books by former *Phoenix Rising*

---

15 As of January 2013, preliminary plans have been made for PSAT to apply for a grant to set up a reading room in the Parkdale Activity-Recreation Centre, a drop-in social agency in Toronto’s west end.
editors that document their peers’ and colleagues’ thoughts and insights on major events long after they had taken place: *Call Me Crazy: Stories from the Mad Movement* (Shimrat 1997) and *Shrink Resistant: The Struggle Against Psychiatry in Canada* (Burstow and Weitz 1988). While both have been out of print for years, I managed to procure copies through Alibris.com, an online network of independent booksellers specializing in used books.

It should be noted that the copyright of all excerpts from defunct periodicals remain with their authors. Despite reasonable efforts, most of these authors are now untraceable due to the passage of time, the intervention of death, the absence of any successor organizations to their editorial collectives, and authors’ routine usage of mononyms, initialisms, and pseudonyms. Some atypically long quotations from *Madness Network News* appear in chapter 3 only because the original texts are not available for consultation elsewhere, either online or in print. For clarity’s sake, embedded citations referring to works from *Madness Network News* and *Phoenix Rising* include the acronymic tags *MNN* and *PR*, respectively.

4. **Ethnographer or Voyeur?**

“It’s a leftwing firing squad! What you do is, get in a circle, turn the guns in on each other, and pull the triggers.” (MacDaniel, on infighting within radical political communities)

I must conclude this chapter with a vital caveat. There are many counterexamples to each of the anti-psychiatric arguments explored in the remainder of this dissertation, and, by analyzing how debates have played out on the ground, I may appear to be making implicit ethical judgements about participants. Even if unintended, undertaking such an analysis necessarily runs the risk of reproducing an impression that individuals who resist or reject psychiatry are unreasonable or unusually volatile; indeed, by exploring moments of strife, I run the risk of caricaturing psychiatrized people as socially inept, dysfunctional, or, indeed, “crazy.” I want to be mindful of Paul Farmer’s insight that “writing of the plight of the oppressed is not a particularly effective way of assisting them…‘everything you say about them will be used against them’” (2005: 26, partly paraphrasing Nader 1972). However, I also do not want to romanticize what I witnessed in the field, for that too would be to betray the social realities of my informants’ lives. There were times when a plurality of my informants were either embroiled in some sort of irresolvable conflict, or allied with one side against another. Some barely tolerated each other; others spent considerable time and energy trying to persuade me of the hypocrisies and moral failings of this or that other person, or group of people. It would be disingenuous for me to sanitize these observations. To do so—to erase my informants’ boiling feelings of insult and injustice in order
to paint a more congenial portrait—would make me complicit with the economic, gendered, and racialized inequalities that motivated their critiques of friends and former friends.

I also do not want to feign agnosticism in the name of objectivity. Even if counterexamples to anti-psychiatric arguments abound, voluminous bodies of research suggest that there is truth to many of them—and, in certain cases, not merely a kernel of truth but a fair amount of documentary evidence. It is now well-known, for example, that pharmacological researchers commonly rely on corporate sponsorship and that the pursuit of profits/patents can lead to the fudging of experimental data (Healy 2006, Lexchin and Mintzes 2004, Paris 2008). Many former patients have spoken out about harmful, deceptive and dehumanizing practices employed in psychiatric facilities (e.g. Capponi 2003, Funk 1998, Shimrat 1997), and many scholars have written about the disproportional psychiatrization, past and present, of women, sexual minorities, political dissidents, the urban poor, and colonized populations (e.g. Anderson 2006, Loomba 2005, Scull 2009, Stoppard and McMullen 2003). It can hardly be denied that the dissemination of psychiatric and psychological vocabularies throughout civil society has had far-reaching effects on how we understand our selves, moods, thoughts, friends, and neighbours (Danziger 1997; Rose 1998, 2002). In other words: the problematic dimensions of “psychiatry,” however defined, are not just the concocted fictions of its critics.

I have adduced this litany of reminders as a caution against the notion that laypeople acquire radical or unorthodox views only because they lack our scholarly impartiality. During discussions with other graduate students, I have at times detected an implicit—sometimes explicit—assumption that people with anti-psychiatric politics are naïve or cruel, and that my task as a fieldworker has been to determine the origins of their unreasonable antipathy toward psychiatry or their mean-spirited desire to make psychiatric services less accessible to others. While an exegesis of these moments is beyond the scope of this thesis, I want to suggest that they reveal the extent to which “impartial” stances are functions of positional privilege. As Linda Andre (2009: 15) has argued in relation to her own experiences following a series of ECT treatments that left her with several years’ worth of permanent memory erasure, leaving her with

16 On two separate occasions, I was asked by colleagues if I ever explained to my informants that militating against ECT has the effect of depriving future patients of a potentially effective treatment. Leaving aside the fact that grassroots campaigns to abolish specific psychiatric treatments are virtually never successful, it is worth recalling that “it is commonplace in medicine… to withdraw treatments and devices that have caused serious harm to a small percentage of people, even though they may have helped a very large percentage” (Breggin 2008: 250). In addition, it is worth noting that while recipients of ECT routinely call for its abolition, recipients of other medical procedures do not typically launch such campaigns (Burstow 2006a: 373).
no recollection whatsoever of her college years, including her memories of entire friendships, learned skills, and personal achievements,

While criticism of psychiatry… is dismissed by professionals as nothing more than a by-product of what one calls “the hippy-dippy sixties” [quoting Edward Shorter, a historian of medicine], this supposedly self-evident statement completely misses the point. We who have experienced psychiatry are motivated by our own experiences, not by events that happened before we were born. Many of us can never forget the injustice of being locked up against our will when we had committed no crime, often on the basis of nothing but a lie by a family member, and then forced to submit to terrifying and damaging “treatment.” Others came to psychiatry voluntarily, fully expecting (and paying for) help, but were swallowed up, dehumanized, and deeply harmed instead.

In other words: is it really so unusual to develop an aversion to something that causes you harm, or to want to prevent others from being similarly harmed? Isn’t it normal to react to humiliation with resentment and outrage? It may also be instructive to consider an insight of an informant who helped me to see the underlying problematic in a new light, albeit along a somewhat different line than Andre’s. At the end of a late-night conversation in which she recounted the way in which virtually her entire embodied self—her facial features and expressions, accent, weight, body odour, eating habits, childhood memories, conjugal history, and sexual orientation—became a justification for increasing numbers of diagnoses and coercive interventions during her teenaged years, she concluded, “It’s not that I’m anti-psychiatry. Psychiatry is anti-me.”

Philippe Bourgois (2003: 18) has observed that “Under an ethnographic microscope everyone has warts and anyone can be made to look like a monster.” In light of this, I want to make a final point that may not be obvious prima facie: by calling attention to internal conflicts within anti-psychiatric resistance movements, I do not mean to suggest that these conflicts are ontologically different from those within other social justice movements. To take just a few examples: the North American labour movement has been riven with highly acrimonious debates and disaffection around the marginalization of non-white and female labour organizers (Chong 2008, Fletcher and Hurd 2000); queer activists regularly debate the ethicality and strategic desirability of demanding the legalization of same-sex marriage (as compared with other goals that are less normatively liberal/bourgeois, Lee Badgett 2009: 129-174, Kazin 2011); environmental movements have been divided over whether publicizing anthropogenic climate change inadvertently serves the interests of the nuclear power industry (Caldicott 2006, Savage and Soron 2011); and the Occupy Wall Street movement has been roiled in debates around the misogynistic and racist conduct of some of its participants. Social movement organizations bifurcate, merge, disintegrate, and go defunct all the time, sometimes within just a few years or months, and these events are often preceded by considerable acrimony and burnout (Goodwin et
What’s more, people routinely participate in, identify with, and draw from the vocabulary of more than one social movement. Anti-psychiatric resistors are no exception: many of my informants were active in other anti-oppression communities in and around Toronto (e.g. antiwar organizations, accessible education campaigns, queer youth groups), and debates that originated in these other groups also made periodic appearances in my field interviews. As Parekh (2005: 194) points out, those who seek social justice will not be able to avoid debating its contours, and “since justice itself is part of the conflict, it cannot tell us how to resolve it.”
Chapter 3
Changing Minds: Psychiatry and Anti-Psychiatry in Historical Context

1. “She’s Not the End-All, Be-All of this Thing.”

I did not answer quickly enough when Ana asked me if I had ever heard of Elizabeth Packard and, as a result, she rolled her eyes and refused to start her car. It was a damp December evening and we were sitting in the parking lot of a Markham strip mall where we had just spent an afternoon searching for a particular rust-proofing product that she wanted. Our conversations had cantered in all directions throughout the day but, for some reason, I had not anticipated this particular topic shift. “No,” I replied. “Who is she?” She threw me a look of mild shock, and I began to worry that my academic credentials were suddenly in doubt. In a slow and delicate manner, she explained that Elizabeth Packard was the “grandmother” of the psychiatric survivor movement and a pioneering figure in the history of anti-psychiatry activism.

Ana then clucked her tongue admonishingly. “If you don’t even know who Elizabeth Packard is…” The warning dangled, and she did not complete the sentence. But the message was clear enough. I acquainted myself with the name as soon as I could, and discovered that it was associated with the following events:

In 1851, the Illinois State Legislature passed a bill prohibiting people from being forcibly institutionalized in the state’s insane asylum without a public hearing to determine whether they were truly insane. The one exception to this was that men could have their wives committed without their consent at any time. And so, when, after fifteen years of marriage, Elizabeth Packard (née Parsons Ware) began to express disagreement with her husband Theophilus’s religious views, he decided that she had gone insane and arranged to have her institutionalized. On June 18th 1860, the county sheriff and two physicians arrived at the Packard household and took her into custody (Levison 2003: 1008).

Elizabeth spent the next three years in the Jacksonville Insane Asylum, during which she refused to agree that she was insane, and, with her fellow inmates, engaged in repeated acts of sabotage against the asylum’s management (Himelhoch and Shaffer 1979: 354-355; Carlisle 2004). Due in part to pressure from her children, who did not believe that she was insane and wished to see her released, Elizabeth was declared incurable and discharged in 1863 (Himelhoch

---

17 To avoid confusion, I refer to Elizabeth and Theophilus using their first names rather than their (shared) last name. In her memoir The Great Drama, Elizabeth indicated that the main points of contention were her insistence on performing missionary work in the community instead of staying at home where Theophilus thought she belonged, and her refusal to listen to him recite Biblical verses on female obedience (1892, vol. 4: 261).
and Shaffer 1979). When she returned home, Theophilus imprisoned her in their house’s nursery by locking her in and nailing the windows shut. She learned that the Jacksonville asylum had refused to readmit her, and that he was therefore arranging to have her committed at an asylum in Massachusetts. Before this could occur, she managed to slip a note through her window frame to a friend who then initiated a writ of habeas corpus (Levison 2003: 1013-1014; Sapinsley 1991). Theophilus was ordered to appear before a judge to explain why he kept his wife imprisoned.

The trial began on January 12th 1864 and lasted five days. The judge determined at the outset that the question to be resolved was that of Elizabeth’s sanity and not her false imprisonment, and he consequently empanelled a jury to hear both parties’ arguments. Theophilus’s legal team produced witnesses from his family and congregation who testified that Elizabeth had argued with him about religious matters, which they all agreed was a sign of insanity. The Jacksonville asylum’s statement that she was “incurable” was also entered into the court record. Elizabeth’s legal team, in turn, produced witnesses who knew the Packards but were not members of Theophilus’s church; these witnesses testified that they never discerned any signs of insanity in Elizabeth, even when she argued with her husband (Himelhoch and Shaffer 1979). The final witness was a physician and theologian who testified that, although he disagreed with some of her beliefs, “I do not call people insane because they differ with me. I pronounce her a sane woman and wish we had a nation of such women” (Moore 1866: 38; see also Levison 2003: 1021).

On January 18th, after seven minutes of deliberation, the jury ruled that Elizabeth was legally sane and should not be confined (Levison 2003: 1015). She discovered upon returning home, however, that Theophilus had rented their house to another family and absconded with her belongings and three youngest children to Boston. She appealed to the Supreme Courts of both Chicago and Boston, but had no legal redress as married women in these states had no property rights. By selling subscriptions to a series of monographs in which she recounted the events surrounding her ordeal at Jacksonville, Elizabeth was able to both support herself and raise awareness about the deplorable conditions in psychiatric wards. She wrote extensively, visited inpatients, and lobbied for the right to a public hearing prior to forcible institutionalization to be extended to married women. She eventually succeeded: in 1867, the Illinois State Legislature unanimously passed the “Personal Liberty Bill,” which gave anyone accused of insanity the right to a jury trial (Himelhoch and Shaffer 1979: 361). She also helped to draft and advocate a bill protecting the earnings of married women, which was passed in April 1869 (Carlisle 2010: 158). Elizabeth was consequently able to purchase a house with the proceeds from her books and
reunite all of her six children under her own roof in June 1869 (Himelhoch and Shaffer 1979: 365-366). Although they never divorced, Elizabeth and Theophilus remained separated for the rest of their lives.

Elizabeth’s activism played a major role in the passage of thirty-four bills in various state legislatures, including Illinois, Iowa, and Massachusetts, all of which were designed to safeguard the rights of people accused of insanity (Himelhoch and Shaffer 1979: 374). However, unlike Dorothea Dix—a contemporary of Elizabeth’s, who was celebrated during her lifetime as an advocate for the insane because she promoted rather than attacked the American asylum system—Elizabeth was stridently censured by medical professionals of the era, even long after her death in 1897, and she died in relative obscurity (Carlisle 2004, 2010). Indeed, many of the bills for which she lobbied were repealed by 1896, including the Illinois “Personal Liberty Bill” (Himelhoch and Shaffer 1979: 373). It was not until the 1960s that she was rediscovered and assigned new significance as a foremother of the then-burgeoning anti-psychiatry and civil liberties movements, especially by writers critical of biomedical models of insanity (Carlisle 2010: 11; Hartog 1988: 83; in reference to Chesler 1972, Szasz 1963, and others).

A few weeks after my parking lot conversation with Ana, I asked her friend and self-described “anti-psychiatry agitator” Cassidy whether she had heard of Elizabeth Packard. She rolled her eyes, immediately recognizing the origin of the query, and did not answer directly.

“Don’t let Ana tell you what you should and shouldn’t have to know,” she said after a chuckle and a long sigh. “She’s not the end-all, be-all of this thing. Why don’t you ask her one of these days why she won’t acknowledge that factory farms and nutrient deficiencies have anything to do with schizophrenia?”

*   *   *

Like a ghost, Elizabeth Packard floated into many other conversations that I had during my fieldwork, always in very different contexts. Her story was used to substantiate the argument that financial affluence can deter forcible institutionalization as well as the counterargument that it cannot; to situate modern psychiatric survivor resistance in an unbroken historical continuum as well as to draw attention to categorical differences between past and present resistance efforts;\(^{19}\)

---

\(^{18}\) Inspired by social reforms she witnessed during a 1836 visit to Britain, Dix (1802-1887) began investigating and documenting the indignities to which indigent “lunatics” were subject in the United States: ostracism, physical abuse, incarceration in unregulated private homes, and so on. She presented numerous reports on these issues to state legislatures, which eventually led to the establishment of several public mental hospitals (Muckenhoupt 2003).

\(^{19}\) Elizabeth did not wish to destroy the asylum system; she sought only to make it a place of absolute last resort. To this end, she advocated a redefinition of insanity that required the identification of aberrant acts rather than aberrant
to illustrate the merits and demerits of joining a movement, to test for gaps in people’s historical knowledge; and to also dismiss the notion that a familiarity with canonical figures is a prerequisite to authentic participation in a social movement. In light of the frequency of these historiographic moves and others like it, it rapidly became clear to me that there was in fact no unitary stance that could be unproblematically called the anti-psychiatry position—or, for that matter, the psychiatric survivor position, the Mad Pride position, or the neurodiversity position. On several occasions, I attempted and abandoned the project of drawing up a taxonomy of these communities’ distinguishing ideological and tactical characteristics: the task became untenable when I realized that the differences within each community were at least as great as the similarities between them, and that I was encountering the same names, faces, and arguments (both historical and contemporary) over and over again in all of them. What’s more, I eventually came to realize that actors in these political configurations were, in practice, more often unified or divided by events than by the “collective identities” to which they nominally belonged.

Chapter 7 will explore the internal dynamics of this phenomenon in some detail.

In her semi-autobiographical book Call Me Crazy, anti-psychiatry activist and self-described “escaped lunatic” Irit Shimrat (1997: 3) acknowledges that

Our movement has many names and many aspects. It has been called the mental patients’ liberation movement, the antipsychiatry movement, the psychiatric survivors’ movement (psychiatric survivors are people who consider themselves to have survived, rather than benefited from, psychiatric treatment), the c/s/x movement (Consumer/Survivor/eX-patient). … in the interests of simplicity, I’ve used the term “mad movement” in this book.

In one short paragraph about vocabulary, Shimrat has captured four decades’ worth of developments in the history of Western anti-psychiatric movements, and I, too, will argue that all of these iterations are irrevocably linked with and constitutive of each other. However, in what follows, I try to avoid using the definite noun “the movement.” Contrary to the collectivized image it evokes, which suggests a shared “strategy or intentionality” based on coalescing patterns of social experience (Patton 2005: 225), what I encountered in the field was a heterogeneous landscape of grievances, aspirations, and malleable descriptors leveraged by beliefs (Carlisle 2010). As will be discussed in Chapters 4 and 6, a definition of mental illness that is based on how people act, rather than how they think, smuggles in its own problems.

---

20 Elizabeth was known to have distanced herself from organized women’s groups and to have maintained a certain aloofness toward other activists of her era, such as suffragists. She did not believe that married women should be entitled to vote, although she did express solidarity with abolitionists and frequently drew equivalences between the social position of white women and that of African American slaves (Levison 2003: 1026-1027). In 1875, she declared before a Congressional committee that “I work under no organization or party” (Burnham 1971, quoted in Himelhoch and Shaffer 1979: 372).
individuals who conceptualized and contested “psychiatry” in very different ways, and who were sometimes thrilled to disavow a given project or group if they felt it did not serve, or hold, their interests. People who at first described themselves as “anti-psychiatry” or “Mad” would later modify, qualify, deny, or recant those identifications when new events rendered them problematic, sometimes within the same week or month. Others stuck tenaciously to a preferred identifier (“psych survivor poet,” “madwoman,” “neurodiverse man,” “anti-psychiatry activist,” “C/S/X-ish,” or the somewhat tongue-in-cheek “orthomolecular evangelist,” in reference to a nutrition-based approach to mental health) even when expressing opinions that—as others sometimes hotly argued—contradicted those identifiers. And people whose experiences did not map cleanly onto prototypical images of authentic psychiatrization could find themselves having to repeatedly justify their stake in a given community. I soon came to view the groups I worked with not as instantiations of a concrete ideal (“the movement”), but as ephemeral networks of individuals whose dissident attitudes toward psychiatry had arisen from a wide range of personal tragedies, thwarted ambitions, traumatic encounters, and philosophical convictions that could just as easily divide as unite. In this context, it is vital to recognize that dissidence and activism are not synonymous (Johnson 2005). For instance, Cassidy, one of my most staunchly anti-psychiatric informants, had not ever engaged in what the social movement literature calls “direct action”—although she did refer to herself as part of “the movement.” Other informants rejected the label “activist” almost as fiercely as they rejected psychiatric labels (e.g. MacDaniel, see chapter 6). As McLennan (2005: 311) has suggested, the refusal to defer to a collective is a key element of the resistor’s toolkit; indeed, as we will see, a person’s quiet, disillusioned withdrawal from a community can be a meaningful gesture of political defiance that is not easily captured in conventional definitions of political activism. In short, the history of counter-hegemonic struggle is not always, or only, the history of collective or collaborative struggle.

As with diagnostic labels, the nomenclature is not as important as the events that underwrite them. My objective in this chapter is dual. I will first briefly review the historical origins of Western psychiatric institutions as we know them today, with a focus on asylums and the Diagnostic and Statistical Manual of Mental Disorders (DSM), in order to provide cultural context to the emergence of anti-psychiatric social movements and counterculture in the mid- to late twentieth century. I will then contextualize the primary historical data preserved in copies of Phoenix Rising (a Canadian anti-psychiatry magazine, 1980-1990) and Madness Network News (an American anti-psychiatry newspaper, 1972-1986) within secondary historical accounts and my own conversations with former participants. In so doing, I will review the rise of modern
anti-psychiatric discourses, with a focus on how ideological reconfigurations and tactical realignments during the 1980s exacerbated existing rifts within resistance networks, and introduced new ethical and strategic quandaries that are debated to this day. In this way, this chapter will set the stage for all subsequent chapters in this thesis.

To appreciate the epistemological complexity of these debates, it is useful to reflect on the challenges of defining an object of political dissent. Raymond Williams’ theorizations on how lexical items shed and acquire semantic features when migrating into and out of different domains of use are instructive here (see also Foucault 1980a; Gee 1996). As Williams (1974: 9) has pointed out, “When we come to say, ‘we just don’t speak the same language’ we mean… that we have different immediate values or different kinds of valuation, or that we are aware, often intangibly, of different formulations and distributions of energy and interest.” To illustrate the divergent valuations that draw some parties together while pushing others apart, here are some excerpts from discussions in which my informants directly or indirectly addressed the question, “What is psychiatry?”

- **[It’s] an extension of the prison-industrial complex**… it lets them lock you up. No trial. For life if they want. You can’t do shit about it. Where else do you get that? Fascist states! [another participant: You got it, sister!] … It is Corrections Canada with no due process. … You know, it is so funny. You can talk about Elizabeth Packard, and every—even to folks who don’t know the story, you just tell it—and every feminist in town knows, like that ((snaps fingers)), what they did they did cause she—you know what I mean, she didn’t ((mockingly)) know her place. But bring up today, like cases from now—getting locked up cause we don’t know—don’t fit in, we don’t act right. And it’s, Whoa. ((points with her index finger)) Life [i.e. give them a life sentence].

- Well, who benefits [from psychiatry]. Not the person. The people who don’t benefit from the person. … It’s a dumping ground for kids who won’t shut up or, like, your wife who won’t blow you. … Like this Packard thing. What, ‘Oh, my woman is pissed off all the time, I’ll get my buddy [the doctor] to take care of it instead of, like, asking why I piss her off so much.’ Like, she’s not doing her job, throw her out. Or like this, yeah—it’s putting science over humanity [another participant: Using science to justify inhumanity?] Yeah, yeah, that.

- Look, it is just torture and brainwashing. … it is lobotomies, insulin [insulin comas], uh, solitary rooms, ice baths, uh, kicking you, and then it’s shock and drugs that make you drool. **No science. Just, like, infinite degradation.** ‘You wanna be like us, you just don’t know it, so I’ma hurt you till you do!’ … That’s what makes psychiatry psychiatry. [That’s why] there’s no such thing as psychiatric ((makes air quotation marks)) consumers.

- **Yes, it is a science. What’s different about it than any other science where funding comes from industry?** Like, what a big surprise—here’s a hundred million dollars, you rub numbers against each other and—and now my merchandise is saleable. … Actually, sometimes I feel like—you know how [another participant]’s always calling [psychiatry] a pseudo-science cause historically, yeah. It’s like, well, wait a minute. What a gift to the conglomerates. Cause now—you see it, the ads?—they go, ‘Our drugs are really much better now, so yes it’s true we used to be kind of pseudo-scientey, but’—do you know what I?—‘but that was then, this is now. **Now we are a science, capital S.**’… And, right, we are consumers, cause all consumers are lied to.

- If we look at the Lizzie Packard story, okay? Does it tell us about brain damage or does it tell us about how woman-hating works? The problem is, we’re so bent on the sensational stuff—like, [electro]shock and
doctors who are, like, twirling their moustaches. We are missing the bigger picture, okay? Which is, psychiatry is not about the institution. It’s about, ‘You’re not who I think you should be, so you must be sick.’ Which doesn’t happen in the psych ward! … It’s parents, friends… it’s not violence, stigma doesn’t work like that. You don’t need to be a psych survivor for everyone to think you’re crazy. … Like racism is not just, like, burning crosses on your driveway, it is also the white girl that thinks she’s so cool cause she doesn’t need a fork to eat sushi… We are all psychiatrists unless we work at not doing this shit!

Without meaning to reify the multiple significations evident in the above excerpts, I want to suggest that they operate along a continuum, in which dissenters may identify “psychiatry” as a set of problematic clinical practices (unscientific, disturbingly violent, and/or transgressive of individuals’ rights), as a handmaiden of problematic interests and priorities (overly scientific, disturbingly peaceful, and/or transgressive of society’s rights), or as an intersection of several of these claims. I do not mean to simplify the complicated, composite arguments that I encountered in the field, few of which were wholly exclusive of each other. However, I would suggest that the image of a continuum is a helpful starting point for understanding how and why internal tensions arise within groups—and within individuals—as well as how and why different modes of critique and resistance have arisen in the times and places that they have.

In practice, “psychiatry” is a richly polysemous word that can be leveraged in support of many different strands of social critique, not all of which sit comfortably alongside each other. The above critiques nonetheless do wrestle with a common observation, namely that a relatively small number of people have historically been entitled to make sweeping decisions and totalizing truth claims about a relatively large number of people’s lives, interior natures, and fates. In addition, most are underlain by the insight that certain modes of prejudicial reasoning are widespread outside of psychiatric wards, allowing some people to be psychiatrized more easily than others. A major repercussion for today’s society is that mainstream biopsychiatric discourse has become “so dominant that language users have little choice but to contend with it in some fashion, whether they appropriate the discourse with reflexive acceptance, mild modification, or dramatic resistance” (Danforth and Navarro 2001: 173-174; emphasis in original). Indeed, the acceptance of some biologized and psychologized notions as a prerequisite for rejecting others is a recurrent theme in anti-psychiatric discourses and initiatives, past and present.

2. From Manacles to Manuals: Defining Objects

2.1 Populating the Asylum: The 17th and 18th Centuries

While medical explanations of “madness” are sometimes traced back to antiquity (e.g. Hippocratic and Galenic theories about its humoural causes), historians have pointed out that it is a category error to assume that any sort of institutionalized mental health field existed prior to
the turn of the 18th century (Crossley 2006; Porter 1987, 2002). Before then, all physicians tended to treat all maladies, and the practice of medicine was mostly undifferentiated in the West: it was not considered a branch of scholarly inquiry (natural philosophy) but was instead a relatively unprestigious technical enterprise, whose practitioners performed both surgeries and haircuts (Ackerknecht 1984, Baigrie 2004). Moreover, instances of what would be called “madness” more commonly fell within a religious purview. As many researchers have noted, it was the emergence of a global nation-state system and their attendant wage labour economies starting in the 17th century that gave rise to a conception of the human body as something that had to be intensively managed, disciplined, and known, out of which an equivalency between mad behaviour and medical illness began to take shape (Busfield 1986; Foucault 1964, 1979, 1984; Hindess 2004).

Throughout Western Europe, the breakdown of feudal familial relations and the rise of new forms of socio-economic marginality within urban centres produced increasing numbers of dispossessed people, who were directed into workhouses and poorhouses, and “isolated as a condemnation of anyone unwilling or unable to compete for gainful employment” (Rissmiller and Rissmiller 2006: 863). Although members of this heterogeneous underclass—chiefly homeless, kinless, poor and infirm people—were not distinguished from each other on the basis of formal medical nosologies, historical records indicate that madness became an officially identifiable problem at this time, as “lunatiks and … ungovernable and mischievous persons” were said to have caused chaos within cramped and unsanitary workhouses and poorhouses (St. Luke’s Hospital 1750, quoted in Scull 1993: 39), creating a demand for alternative forms of sequestration. With one notable exception,21 however, there is no reliable record of the existence of any institution devoted specifically to the confinement of “mad” people prior to the 17th century (Crossley 2006: 48). This is significant because “madhouses” were the nuclei around which the field of psychiatry eventually materialized.

There were many incentives for 17th and 18th century physicians and laypeople to open private madhouses. These facilities could be highly lucrative for operators who took troublesome kin off the hands of families and charged for room and board (Porter 2002). Affluent families

21 The exception is London’s notorious “Bedlam” hospital, which was originally founded in 1247 as the Priory of the Order of St. Mary of Bethlehem (corrupted to “Bethlem” and eventually “Bedlam,” which is now virtually a synonym for “chaos”). While it is reputedly the world’s first and oldest mental institution, it did not acquire an official medical mandate until sometime in the 17th century. Prior to this, Bedlam was primarily a monastic site; its eventual transformation into “a specialized receptacle for the mad occurred over the succeeding centuries” (Scull 2006: 16). “Cures,” in the modern sense, were not sought for internees, as the goal was principally custodianship in what turned out to be seriously austere conditions (see Andrews et al. 1997).
that could afford to hire third parties to assume caregiving responsibilities found no shortage of candidates in an increasingly entrepreneurial society “in which people eagerly sought new opportunities to gain a living” (Scull 2006: 18; see also Scull 1989). For such families, transferring unruly kin into private hands had the added benefit of keeping them out of the public eye. In addition, the growing prestige of medicine during this era created a demand for increased professional specialization, and “madhouses” supplied one avenue through which doctors could achieve respectability within their communities. Physicians who ministered to the mad did not need to own their own madhouses to benefit from the new trade; many served as paid consultants for multiple independently operated madhouses, and these madhouses supplied convenient spaces for therapeutic experimentation (Scull 2006: 57, 69). Conditions in these sites were often grim—internees were sometimes manacled to beds and walls, and some custodians boasted of an ability to tame them with whips and beatings—although, as Smith (1992: 45) and Porter (1987) remind us, madhouse proprietors cannot be judged by contemporary standards, and 18th century madhouses were not monolithically abusive (see also Porter 2002, 2004; Scull 1993, 2006).

By end of the 18th century, a new therapeutic paradigm called “moral treatment” had emerged in France, Italy, and England, whereby physicians tried to rehabilitate patients by habituating them into “middle-class standards of conduct,” and “ideas about respectability and a daily routine” (Reaume 2009: 11, 14). Advocates of “moral treatment,” who were initially considered a threat to medical orthodoxy (Scull 1989), espoused a shift away from “external, physical coercion, which might force outward conformity, but which could never produce what was now seen as the essential internalization of moral standards” (Scull 2006: 71, emphasis in original; see also Wright et al. 2008). The rise of this paradigm may have contributed to legislative reforms requiring the state to monitor the internal operations of private facilities; in 1774, for example, it became a legal requirement for British madhouses to be annually licensed by the Royal College of Physicians and their inmates certified by a medical examiner (Wright et al. 2008: 232; this was the origin of the concept of “certifiable” madness). While these reforms were in part motivated by the published writings of former inpatients identifying themselves as “alleged lunatics” who had been wrongfully confined, it is important to note that all of these people were “literate, well connected and well resourced,” and were therefore “not average madhouse inmates” (Crossley 2006: 53).

Private madhouses were in decline by the turn of the 19th century, and there is evidence of a sharp increase in the construction of public asylums throughout Western nations (Scull 1993; Shorter 1997: 34, 46-47). The first publicly funded insane asylum in the United States was
opened in 1773 in Williamsburg, Virginia (Shorter 1997: 45). In 1807, a British parliamentary select committee recommended the construction of public asylums throughout the United Kingdom (Crossley 2006: 52). Toronto’s first public asylum, the Provincial Insane Asylum, was opened in 1841 (Reaume 2009: 6). Public asylums were in theory intended to reproduce a domestic atmosphere for inpatients, and advocates like Dorothea Dix argued passionately about the need to expand the asylum system by drawing upon an Enlightenment discourse of care (Gollaher 1995, Muckenhoupt 2003; see also Everett 1994). In practice, however, asylums were designed with security rather than therapy in mind: they had high walls, locked doors and minimal furnishings, stays were long, wards were “overcrowded, underfinanced, and burdened with chronic patients,” and treatments consisted mainly of physical restraints (Dain 1989: 5). By the close of the 19th century, the “central mission of institutional psychiatry had been reduced to quarantining the incurable, rather than restoring the temporarily distracted to sanity” (Scull 2006: 83). Indeed, as asylums grew more numerous over the course of the 19th century, “so did the relative proportion of the general population officially diagnosed as insane” (Crossley 2006: 55).

Three overlapping hypotheses have been advanced to account for this trend. Joan Busfield (1986) suggests that as industrialization shifted work out of homes and into factories and assembly lines, labourers became less available to care for infirm, disabled, or elderly kin. Such individuals became financial burdens on their families, for whom the increasing availability of public asylums might have been a relief. Andrew Scull (1993) argues that because definitions of lunacy were vague at this time, this meant in practice that diagnostic criteria could be expanded or contracted depending on the availability of psychiatric facilities—in other words, the existence of nearby asylums lowered families’ and communities’ thresholds of tolerance for unruly behaviours, and created a steady supply of “certifiable” people. Ian Hacking (1999, 2002) argues that the increasing commitment rates were, in effect, artifacts of a criminological turn in psychiatric practice that occurred in the wake of the Industrial Revolution (see also Wright et al. 2008). Increasing socio-economic disparities created subpopulations that the educated classes could scrutinize, and from the early 19th century onward physicians increasingly conceptualized suicide, prostitution, drunkenness, vagrancy, and petty crime in terms of mental illness. Their innovation of new diagnoses not only created convenient, professionally

---

22 As one critic of this trend noted in the 1870 Edinburgh Review, “If we make a convenient lumber room, we all know how speedily it becomes filled up with lumber. The county asylum is the mental lumber room of the surrounding district; friends are only too willing, in their poverty, to place away the human encumbrance of the family in a palatial building at county expense” (quoted in Scull 1993: 373-374).
advantageous tools to explain away the social upheaval of the era, but actually created new illness labels that did not previously exist, which in an iterative fashion could then be applied to more and more people.\textsuperscript{23}

The explosive growth of asylum populations during this era is sometimes attributed to authorities’ increasingly precise methods for identifying biologically impaired individuals in need of detainment (Shorter 1997). However, it is important to keep in mind that the rise in the numbers of psychiatric inpatients was consistently and disproportionately among the poor (Scull 1993; see also Porter 2002, 2004). While it could be argued that mental illnesses make people poor by making them less capable of earning a living, the direction of causality is not necessarily so simple: all three of the above theories strongly suggest that the economically marginal were more vulnerable to being psychiatrized because they were less able to protect themselves from the judgements of their families and communities, were more likely to have to survive by resorting to criminalized—and hence pathologized—activities, and had more concrete reasons to be despondent or suicidal. While the tendency for socially stigmatized behaviours to be pathologized and socially valorized ones to be normalized is not itself new, nor necessarily unique to what Nikolas Rose (2001) aptly calls the “psychiatric societies” that took root at this time, it is clear that modern criteria for distinguishing stigmatized behaviours from valorized ones owe much of their epistemological authority to the industrializing processes and priorities of the past three hundred years.

2.2 Undesirables at Home and Abroad: The 19\textsuperscript{th} and Early 20\textsuperscript{th} Centuries

During the 19\textsuperscript{th} century, psychiatry (“alienism,” in the parlance of this era) grew enormously as a profession. In 1841, the Association of Medical Officers of Asylums and Hospitals for the Insane was formed, and, by 1853, two international journals existed: the \textit{Asylum Journal of Mental Science} and the \textit{Journal of Psychological Medicine and Mental Pathology} (Mora 1997: 127, Shepherd 1992: 18). In a departure from the “moral treatment” paradigm of earlier decades, journal articles increasingly stressed the physical basis of madness (Shepherd 1992). As Crossley

\textsuperscript{23} The practice of confecting social misery into medical taxonomies became institutionalized in the U.S. national census during this era. As Rose (2003: 409) notes, while the 1840 census documented only one category for “idiocy/insanity,” the 1880 census documented seven discrete categories: epilepsy, mania, monomania, paresis (muscular paralysis, eventually linked to prior syphilis infection, Scull 2006: 133), dementia, dipsonmania, and melancholia (see also Kutchins and Kirk 1997: 38-39). The case of “melancholia” is an instructive example of how cultural paradigms shape disease constructs: for centuries, it was primarily an artistic idiom and did not acquire pathological connotations until health began to be linked with industriousness in the 19\textsuperscript{th} century (Jadhav 2000: 41-65). By this time, “melancholia” began to signify potential truancy, and was transformed from an ephemeral \textit{state} into a durable \textit{trait}: something to be and have, rather than something to feel and express.
(2006: 58) notes, by the second half of the 1800s, “Lunacy was increasingly viewed, contrary to earlier claims about moral treatment, as an organically rooted illness which required proper, medical treatment,” and, indeed, it became normal psychiatric practice “to interpret symptoms in terms of the internal organic malfunctions that were their cause” (Rose 2003: 412). To this end, emetics, laxatives, opium, hot and cold baths and other somatic interventions were administered to asylum inpatients, although “cure” rates remained low (Crossley 2006: 58). It is important to note that psychiatrists’ location of mental illness in the bodily interior at this time did not take root in an epistemic vacuum: major paradigm shifts in biological theory had already given rise to an understanding of the human body as a mechanical entity, and physicians, politicians, and philosophers were increasingly recasting dysfunction and maladjustment in terms of organic malfunction at this time. By the late 19th and early 20th centuries, English, French, and American asylum wards were overflowing with inpatients, many of whom were diagnosed with a catchall label of “feeblemindedness” (Joseph 2005), and, indeed, the size of asylums had accordingly expanded, such that “institutions containing a 1,000 and more were common” (Scull 2006: 117).

While some psychiatrists ministered to the “feebleminded” in the Western metropole, others found assignments in the Eastern and Southern hemispheres, where growing numbers of colonial administrators sought their services. Psychiatrists did not typically participate in imperial policy debates and their formal impact on colonial governance was negligible (Littlewood 2002: 20). However, “in ideological rather than directly practical ways, the often ill-trained and generally under-resourced medical practitioners who entered this arena did help underwrite colonial systems of domination” (Scull 2008: 412; see Mahone and Vaughan 2007). That is, colonial psychiatry was instrumental in the forging of imperial discourses that normalized certain bodies (white, masculinized, propertied, elite) by pathologizing certain others (dark skinned, feminized, proletarian, criminalized), a move that has had a determining impact on biomedical research to this day (see also Bamford 2007, Nerlich et al. 2004).

Cultural shifts in Western conceptions of the bodily interior during the Renaissance made it possible for behavioural problems to later be explained in terms of malfunctioning biological parts. Andreas Vesalius’s 1543 publications on dissected human cadavers destabilized Galenic and Aristotelian ideas with a “new conception of the human body as an assemblage of interconnected parts” (Baigrie 2004: 40-41) and the 17th century ferment of new technologies such as looms, furnaces, forges, kilns, piping systems, and irrigation ditches “created a new stock of metaphors” for anatomists to represent processes like blood circulation, respiration, and pain sensation (Miller 2007: 45). It is important to note, however, that mechanical metaphors interact with other metaphors. Cartographic and colonial metaphors are highly serviceable to the view that “malfunctioning” patients are victims of unruly body parts that must be mapped, mined and tamed (Lippman 1992, Rosner and Johnson 1995). Indeed, the view that discrete parts and processes are discoverable resources that can be extracted, manipulated, reverse engineered, redeployed, named after, and owned by the discoverer exerts a powerful influence on theoretical and methodological directions in biomedical research to this day (see also Bamford 2007, Nerlich et al. 2004).
on the lives of many generations of “pathological” Others. This venture was underpinned by three related precepts: the notion that distinct races were in distinct phases of social, psychological, intellectual, and moral development, with the white race crowning the evolutionary hierarchy; the notion that psychologically underdeveloped “natives” were thus unqualified to administer, and minister to, themselves; and the notion that Westerners were consequently obliged to bring knowledge, technology, government, schooling, medicine, and health to the indigenes of these distant outposts (Anderson 2006, Keller 2007, McElhinny 2005, Swartz 1995). Together, these imperatives comprised the “White Man’s Burden,” a rhetorical construct that served to mask the coextensivity of these infrastructural “gifts” with extractive enterprises, exploitative economies, and settler and military violence.

By supplying colonialism with a humanitarian alibi, the White Man’s Burden created new research agendas for colonial doctors, whose writings confected the entirely sensible rage, despair, and anguish of “natives” into clinical diagnoses that masked the role of colonial violence in their suffering. As Frantz Fanon later noted, colonized peoples’ resistance was routinely “attributed to religious, magical, fanatical behavior” (1965: 41, quoted in Loomba 2005: 120) and seen as evidence of an inability to adapt to modernization. Fanon (1963, 1967), in contrast, pointed out that it was colonialism and its outcomes—humiliation, dehumanization, alienation—that was pathogenic, not modernization initiatives. For Fanon, madness was “the paradigmatic sickness of colonialism” (Keller 2011: 199), but for European and American psychiatrists of the colonial heyday, madness was paradigmatic of anti-colonialism. During the height of French rule over Algeria, for example, the French psychiatrist Adolphe Porot published a treatise on the “mental puerilism” of North Africans, whose “psychopathies” were linked to “simple patterns: a few confusions almost always in the form of stupidity” (Porot 1918, quoted in Fassin 2011: 228). Likewise, the “tendency” of Southeast Asian men to murder white colonists after enduring their insults was portrayed in a 1901 medical text as a disorder (“amok”) born of hypersensitivity, “infantile misjudgment,” “deficient self-control,” “primitive reflex,” “vanity and immaturity,” “racial jealousy,” and a “pathological sense of honor” (Anderson 2006: 141). Such formulations persisted well into the 1950s, when British ethnopsychiatrist J.C. Carothers portrayed the Kenyan Mau Mau Uprising as a pathological outburst rather than a revolt against land dispossession, imparting colonists’ efforts to paint the rebels as irrational and bestial with scientistic credibility (McCulloch 1995, Mahone 2007). To colonial officials, the widespread

---

25 Rudyard Kipling famously coined this term in his 1899 poem *The White Man’s Burden: The United States and the Philippine Islands*. 
incidence of such “disorders” affirmed their view that indigenous populations “lacked the sustained self-control and capacity for reason necessary to become fully civilized,” and were thus in urgent need of European or American tutelage (Anderson 2006: 142).

Such tutelage, however, did not grant colonial subjects who grew up speaking European languages and wearing Western garments the right to be seen, or treated, as the equals of their benefactors. On the contrary, copious psychoanalytic literatures materialized around “native” elites, who were thought unable to withstand the stresses of civilized life or, in some cases, unable to be stressed by civilized life. Indians who had been educated and enculturated into British linguistic and cultural habits, for instance, were caricatured in these texts as “second-class citizens in psychological modernity”—able, that is, to parrot the words and accents of Europeans, but still primitive in thought and blank in mood (Anderson 2004: 298). As Ania Loomba (2005: 118-119) notes, theoretical distinctions between “instinctive and reflective human beings” were prolific literary conventions: throughout the 19th and 20th centuries, fictional depictions of colonial encounters have tended to reserve interior narration and individual traits for white protagonists. Colonized subjects, on the other hand, were “entitled only to drown in an anonymous collectivity” (Memmi 1967: 88, quoted in Loomba 2005: 118). Such representations diminished the need of elite Europeans to define themselves in contraposition with “madmen” in colonial sites, where every darker skinned, flatter nosed person was already an Other (Vaughan 1991: 10; see also Swartz 1995: 52, Stoler 2002). Consequently, asylum systems that walled away the “mad” did not need to be established en masse throughout the colonies for colonial psychiatry to acquire disciplinary status, prestige, theoretical canons, and objects of study.

As Megan Vaughan (1993: 45) has noted, imperial anxieties about Africa and the “Orient” were also displaced onto the Western “working classes and the female sex.” From Freud’s portraits of female sexuality as a “dark continent” to psychoanalytic ideas of the unconscious “as a forbidden zone of irrational desire” (Anderson et al. 2011: 3), geographic metaphors became robust epistemological scaffolds for elevating the elite, white, masculine psyche over its poor, dark, feminine antithesis. Viewed from such heights, the West’s indigent, impoverished, and “feebleminded” classes began to resemble, in essence, failed Europeans: or, in the evolutionary parlance of the time, “degenerates” who had backslid, psychologically and

26 The pathologization of dissent did not begin with the medicalization of 20th century anti-colonial resistance. Notably, in the 1850s, American psychiatrists theorized that black slaves who ran away from their white “owners” suffered from a mental illness called “dрапетомания.” Medical journals of that era also described slaves’ “disrespect for the master’s property” as symptomatic of a condition called “dysaesthesia aethiopis”—the ostensible cure to which was extensive whipping (Metzl 2010: ix; see also Littlewood 2002).
physiologically, due to unhygienic habits or climates. Thus, as Swartz (1995: 39) notes, mental illness came to symbolize “the confrontation between civilization and savagery, through the person of the deranged lunatic.” For instance, Victorian theories about “hysteria” insisted that white middle- and upper-class women developed nervous illnesses when they avoided sex, were unwilling to bear children, and participated excessively in public life. By juxtaposing “hysterical” white women’s alleged frigidity with the alleged fecundity of black and aboriginal women, who “definitionally could not be hysterics,” Victorian doctors accomplished two feats: they transformed white women’s aspirations of autonomy into a threat to the future of their race, and they denied that racialized women possessed the same psychological complexity (and ability to feel pain) as their white sisters (Briggs 2000: 254; see also Scull 2009). Similarly, white colonialists who struggled with tropical climates framed their distress in psychological terms: as attested in many travel diaries and clinical histories, they were terrified of deteriorating into mentally effete, racially degenerate shadows of their once robust selves—terrified, that is, of “going native” and being rendered emasculate (Anderson 1997). In these ways, race, class, and gender were linked in service of “mental health” in the West and abroad, conceived as much as a civilizational project as an individuated psychological status.27

Throughout the West, the threat of civilizational decay was widely invoked to justify eugenicist programs that targeted “vagrants, paupers, mental defectives, drunkards, and criminals” (Oppenheim 1991: 287, quoted in Swartz 1995: 46). To elite observers, poor and criminalized whites seemed like failures of empire (Stoler 2002), and policies aimed at curbing “the breeding of defective, insane, sick, or criminal individuals and their kin” were widely endorsed across the political spectrum from the late 19th to early 20th centuries (Rose and Novas 2005: 443). As Véronique Mottier (2005: 271) reminds us, eugenicist discourses about racial and mental hygiene “were scientific orthodoxy in pre-war Europe and their respectability was little called into question at the time.” Indeed, some eugenic programs were promoted from socialist perspectives: for example, the Swiss psychiatrist Auguste Forel argued that it was unjust to hold people responsible for having flawed hereditary constitutions, and that the enhancement of the national breed should take place not by treating current degeneracy, but by preventing its occurrence (Mottier 2005: 263). Accordingly, throughout the 1920s, 30s, and 40s, “mental

27 None of this is to say, of course, that colonized peoples could not subjectively experience their hardships as serious, involuntary afflictions akin to illnesses. What is important, as Jonathan Sadowsky (1999: 68) argues in his study of colonial asylums in southwest Nigeria, is that classic psychiatric symptoms like paranoid “delusions” are “overdetermined by the persecutory nature of colonialism itself”—that is, it is impossible to cleanly define where the pathogenicity of colonial violence ends, and where any sort of “underlying” illness begins.
hygiene” programs targeting “degeneracy and inefficiency amongst the working class” and the supposed threat that their habits represented to the civic order were introduced in many Western nations, with the rhetorical and material support of educated elites (Crossley 2006: 72). In 1923, a New York Times editorial argued that the mentally ill should not be allowed to marry, and, by 1933, people with a psychiatric diagnosis could not legally wed in any American state (Andre 2009: 29). In 1927, the U.S. Supreme Court ruled that forced sterilization of the insane was legal (Whitaker 2002: 59). In 1935, Nobel laureate Alexis Carrel, a physician at the Rockefeller Institute for Medical Research, argued that mental patients “should be humanely and economically disposed of in small euthanasic institutions supplied with proper gases” (Carrel 1935: 318-319, quoted in Andre 2009: 29). And, in 1942, a leading Cornell University neurologist advocated euthanasia for the mentally ill in the American Journal of Psychiatry, arguing that the “feebleminded people among us” and “hopelessly unfit” who “so largely fill our mental institutions” should be “relieved of the burden of living” (Kennedy 1942, quoted in Joseph 2005: 172-173).

Debates about “mental hygiene” also facilitated the innovation of new psychosurgical techniques, which were designed to improve patients’ manageability within psychiatric wards. During the first half of the 20th century, psychiatry lacked a standardized diagnostic repertory, which meant that techniques such as lobotomies, insulin comas,28 electroshock, as well as all-purpose tranquilizers like Valium were used in an indiscriminate fashion on patients. Inpatient populations throughout the 1920s and 1930s were subjected to a particularly wide range of chemical and surgical procedures, including the artificial induction of narcosis, meningitis, anoxia, and comas (Scull 2006: 88-89). Although the nominal aim was to treat the “feebleminded,” the practical aim was paradoxically to make resistant patients feeble; this was because cure was in fact equated with docility and cooperativity (Lerner 2005). As psychiatrist and electroshock advocate Abraham Myerson put it in 1942,

I believe there have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. I think… that these people have for the time being at any rate more intelligence than they can handle and that the reduction of intelligence is an important factor in the curative process. I say this without cynicism. The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia [mental retardation] (quoted in Andre 2009: 50).

28 Insulin comas were widely used to treat diagnoses of schizophrenia from the 1940s to the early 1960s. The procedure involved injecting patients with large doses of insulin to induce comas or sub-comas. These comas were preceded by symptoms of decreased blood glucose: seizures, perspiration, uncontrollable salivation, and a feeling of intense hunger. Describing his own experience on this regimen, Phoenix Rising editor Don Weitz has stated, “I felt hunger and thirst like I’d never experienced in my whole life… Most of the time, after two or three hours, I was totally drenched in my own sweat, wiped out, scared shitless” (1988: 286).
The eventual decline of theories equating mental infirmity with racial and hereditarian degeneracy had many determinants, one of which was the discovery during the First World War that mentally “normal” soldiers could break down under abnormal stressors—succumbing, for example, to “shell shock” while serving on the front lines. Faced with irrefutable evidence that “the manly heroes who had volunteered for the front” were as vulnerable to psychic breakdown as pauper lunatics, it became difficult for Western psychiatrists to hew too closely to “the notion that insanity was predominantly a symptom of hereditary degeneration” (Scull 2006: 175). Such revelations may have also contributed to the mid-century ascent of psychoanalysis, a paradigm that focused as much on the supposed “pathologies” of middle-class men and women as on their working class counterparts (Showalter 1987). In addition, with the end of the Second World War and attendant revelations about Nazi atrocities, explicit advocacy of eugenics acquired truly disreputable associations. However, eugenic notions about psychiatrized people persist in politer guises to this day (see Pilgrim 2008 for some revealing case studies of eugenic reasoning in modern psychology and psychiatry). As my informants often pointed out, modern public health campaigns urging audiences to imagine and strive for “a world without depression” and other mental illnesses suggest that this imagined Utopia would be free of them.

2.3 Specificity and its Uses: The Mid- to Late 20th Century

Western colonial systems also began to fray in the postwar era, as colonized peoples, long the casualties of eugenicist reasoning, increasingly militated against the Western “civilizing” mission—with weapons and with words. Several major anti-colonial writers who emerged in the 1950s could arguably be called the first modern anti-psychiatry advocates, in that their arguments preceded those of more famous figures like Michel Foucault or Thomas Szasz (see section 3.2). Most notably, Martiniquais psychiatrist Frantz Fanon, Tunisian-Jewish essayist Albert Memmi, and Martiniquais poet Aimé Césaire dismantled the White Man’s Burden’s most frequently invoked justification—the gift of Western medicine—in their works, The Wretched of the Earth (Fanon 1963, original French version 1961), Black Skin, White Masks (Fanon 1967, original French version 1952), The Colonizer and the Colonized (Memmi 1965, original French version 1957), and Discourse on Colonialism (Cesaire 1955, original French version 1950). For Fanon, Memmi, and Césaire, the triumphal narrative in which Western saviours brought cures to the colonies was belied by the inherently pathogenic nature of colonial violence, rape, extraction, discrimination, and subjugation. The introduction of psychiatric facilities into colonized people’s
societies starting in the 1930s and 40s was simply an extension of what had come before: scientific judgements about worthy and unworthy peoples, and “corrective” interventions on the bodies of those who fell on the wrong side of those judgements (Keller 2007, 2011).

By reassigning pathogenicity from the tormented to the tormenter, and identifying violence as an instrument of political radicalization, anti-colonial writers anticipated the arguments of the psychiatric inmates’ liberation movements by two decades (see section 3). For example, to counterbalance Western ethnopsychiatrists’ theories about the innate “laziness” of colonized subjects, Fanon (1963: 239) reframed their findings as evidence of those subjects’ “conscious sabotage of the colonial machine.” In the same vein, he agreed with his French colleagues that Algerians were inordinately violent, but stressed that their rage was “a response to pathological violence, rather than a reliable measure of the Algerian’s ‘primitive’ or ‘criminal’ nature” (Keller 2011: 205). Fanon’s dissidence was nonetheless advanced in a psychoanalytic register that—even if deployed in the service of social justice—continued to pathologize sensible reactions to injustice, and, in so doing, risked reducing geopolitical problems to psychological ones. However, his reliance on psychodynamic models, while complicit in a portrait of Western knowledge regimes as somehow apolitical, pan-cultural, and “separable from [their] conditions of possibility” (Anderson et al. 2011: 16) was understandable given that such models enjoyed widespread respectability at the time. As Lewis (2006a: 3) has noted, it is now sometimes difficult to remember that, like its successor paradigms, “psychoanalysis itself rode in on a narrative of scientific progress” that was not seriously challenged until the 1970s.

Mid-20th century Western psychiatry was, indeed, dominated by the psychoanalytic; from the 1930s through the early 1960s, physicians filled patients’ medical charts with constructs like repression, anxiety neurosis, and phobic neurosis (Littlewood 2002, Luhrmann 2001), and schizophrenia was blamed on emotionally cold “refrigerator” mothers (Scull 2010: 1246). In time, the American public’s “gushing enthusiasm” for psychoanalysis became a double-edged sword for psychiatrists (Luhrmann 2001: 214). On the one hand, psychiatrists were able to capitalize on psychoanalysis’s popularity to shore up their own credibility as diagnosticians of mental pathology; on the other, psychoanalysts threatened medical psychiatrists’ status as the exclusive “arbiter of the mental world,” and the border between the two professions became increasingly blurred (Hornstein 1992: 254; see also Dain 1989, Leahey 1992, Scull 2011). As psychoanalytical terminologies were absorbed into standard psychiatric usage, “previously marginal neurotic and personality disorders” began to take centre stage (Crossley 2006: 59), and middle-class patients suffering from “marital difficulties, financial misfortunes, and anxiety”
who voluntarily presented themselves to psychiatrists and GPs began to be represented in patient populations in higher numbers (Luhrmann 2001: 212-213; Showalter 1987; see also Brock 2006 and Danziger 1997 on jurisdictional struggles within the psychosciences at this time).

It was in this fraught context that the first two editions of the *Diagnostic and Statistical Manual of Mental Disorders* were developed. Psychiatrists and clinical psychologists sought to assert authority over psychoanalytic concepts and “own them by providing the scientific labels” (Samelson 1999: 254; see also Whooley 2010: 465). However, their first efforts arguably backfired. The DSM-I and DSM-II, published in 1952 and 1968 respectively, relied almost exclusively on psychoanalytical perspectives and were designed “to reflect, not to change, the current practice of psychiatry” (Kutchins and Kirk 1997: 41). As Whooley (2010: 453) has pointed out, their “fluid psychoanalytical understanding of mental illness” ended up undermining psychiatrists’ claim to medical authenticity in the eyes of other medical professionals, whose disease objects tended to have fixed definitions (see also Caplan 1996 and Rogler 1997).

Moreover, while the dawn of modern biological psychiatry is sometimes retrospectively dated to the rise of first-generation antipsychotics in the 1950s (Shorter 1997: 255-272, in reference to chlorpromazine and haloperidol, sold in North America as Thorazine and Haldol), psychiatrists of this era openly acknowledged that such drugs were “crude instruments” that suppressed the symptoms but not the underlying causes of illnesses (Luhrmann 2001: 226).

Beginning in the 1960s and 1970s, psychiatry’s public credibility began to ebb in the face of emerging anti-psychiatric countercultures in Europe and North America that, at the time, enjoyed some support in the mainstream public as well as within mainstream academia (see section 3.2). As well, in 1973, Stanford University psychologist David Rosenhan published a landmark study that seriously indicted the diagnostic, prognostic, and therapeutic standards of American inpatient psychiatry. Rosenhan had sent eight “pseudopatients,” including himself, to various public and private psychiatric hospitals across the United States, where they were instructed to gain admission by claiming that they heard voices, to then immediately resume their normal behaviour, and to try to secure their own release. What they found was that once they had acquired a mental illness label, “there is nothing the pseudopatient can do to overcome the tag… all of his other behaviors and characteristics are colored by that label” (Rosenhan 1973: 253). For

However, as Andrew Scull notes, the swift commercialization of chlorpromazine following discovery of its antipsychotic applications does represent a defining feature of the modern biopsychiatric age. Despite being tested on only 104 subjects prior to its 1954 release, within thirteen months, chlorpromazine was being used on an estimated 2 million patients in the U.S. alone (Scull 2006: 143). Its North American licensee, Smith Kline & French—today, GlaxoSmithKline—profited enormously from these sales, and the product has remained in widespread use for nearly sixty years.
example, pseudopatients who asked basic informational questions of their clinicians were ignored; the act of writing was frequently interpreted as further evidence of illness; staff chatted about patients in their presence as if they were not there; and events in their childhood and adolescence were arbitrarily sensationalized in their medical charts. It took between 19 and 52 days for each pseudopatient to achieve his or her release, and, even then, they were assumed to be at risk of relapse. Rosenhan’s study concluded by asking “how many patients might be ‘sane’ outside the psychiatric hospital but seem insane in it” (1973: 257). In part because it had been published in the prestigious journal *Science*, the study achieved widespread publicity as a “powerful token of a more general scepticism that marked psychiatry and asylums at the time” (Coleman 2008: 347).

Reformers in the American Psychiatric Association (APA) “interpreted their profession’s problems as a failure of diagnostic reliability,” arising from a lack of stable nosological categories that could be “explained in terms of specific causal mechanisms located in the body” and targeted with specific biological treatments (Whooley 2010: 452, 453). The APA consequently launched an aggressive initiative in the late 1970s to revise the DSM and devise more accurate diagnostic instruments. Under the direction of Robert Spitzer, head of biometrics research at Columbia University’s Psychiatric Institute, the DSM-III task force redefined the nature of psychiatric objects, with the aim of linking illness and intervention in a measurable, standardized manner (Lakoff 2005: 10-14; see also Horwitz 2002, Rosenberg 2002). As Spitzer stated in a 1979 interview with the *New York Times*,

The manual’s real significance is that it shows psychiatry becoming more of a science. The criteria for making a diagnosis are spelled out with great specificity, and patients will benefit because the diagnoses have treatment implications (quoted in Whooley 2010: 453).

When completed in 1980, the DSM-III was in every sense an entirely new document, which in the ensuing years would permanently reshape the landscape of psychiatric discourse and practice. The DSM-I and DSM-II had been slim booklets “not taken terribly seriously by the field,” and neither had advanced a categorical definition of mental illness (Luhrmann 2001: 227). In contrast, the DSM-III ran to nearly 500 pages, presented lengthy symptom checklists for 265 mental disorders, and introduced a new metric called the Global Assessment of Functioning that defined its object in material terms: mental illness was equated with social and occupational disability (Kutchins and Kirk 1997: 45, Rose 2003, Whooley 2010). As Andrew Lakoff notes,

30 Spitzer pushed for the DSM to assert that “mental disorders are a subset of medical disorders,” although his task force ultimately withdrew this claim to placate the APA-member psychologists who did not wish to speak of mental disorders as biological diseases (Kutchins and Kirk 1997: 30). By the 2000s, however, Spitzer’s preference would be
As a standards regime, DSM-III sought to produce functionally comparable results across disparate domains… if the same person went to two different clinics, he or she should receive the same diagnosis at each site. Based on directly observable traits, and ostensibly atheoretical, the new diagnostic standards structured a broader system of communication. While the epistemology underlying the new manual was positivistic—disorders were out there in the world to be found—its categories were honed according to pragmatic principles: the pathological could best be defined by the dysfunctional (Lakoff 2005: 12).

The new edition was an smash success, with its first revision selling over 1.1 million copies between 1987 and 1993 (Caplan 1996: xx). Five years after its release, psychiatrist Jerrold Maxmen framed the APA’s achievement in the following terms: “On July 1, 1980, the ascendance of scientific psychiatry became official. …By adopting the scientifically based DSM-III as its official system for diagnosis, American psychiatrists broke with a fifty-year tradition of using psychoanalytically based diagnoses” (1985: 35). In the same year, the manual’s chief architect, Robert Spitzer, contended that the new diagnostic entities were etiologically atheoretical and thus represented “an advance toward the fulfillment of the scientific aspirations of the profession” (Bayer and Spitzer 1985: 187, quoted in Lewis 2006a: 4). Spitzer’s claims about the DSM-III’s atheoretical qualities were reiterated by Richard Wyatt of the National Institute of Mental Health, who asserted that

Good psychiatry requires careful observations and descriptions, unvarnished by theory. This point is demonstrated by the changes made from the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) to the third edition (DSM-III); the latter is an attempt to describe things as they are, but the former often blurred observations and interpretations. DSM-III adds objectivity, reliability, and prognostic validity (Wyatt 1985: 2018, quoted in Lewis 2006a; emphases mine).

For Wyatt, Spitzer, and their colleagues, the new manual represented more than a mere paradigm shift; it was a powerful affirmation of their profession’s epistemic allegiances in a cultural milieu that treated the political and the scientific (“unvarnished by theory”) as dichotomous. Within the space of a few short years, formerly received truths became unscientific residues, such that “[t]o the new adherents, psychoanalysis was charlatanry and psychiatric disorder was brain dysfunction” (Luhrmann 2001: 203). Confidence in the DSM-III’s newly empirical merits was not limited to the psychiatric profession. Over the 1980s, the new DSM’s diagnostic codes and standards were adopted throughout Western mental health systems for the purposes of insurance claims, pharmaceutical product development, hospital admissions records, medical school curricula, legal cases, and the tracking of outcomes in health service provision, with the result of solidifying psychiatry’s cultural authority (Whooley 2010, Rose 2004). Nor was the influence of

a de facto reality. In interviews with “pharmaceutical company managers and industry experts, clinical researchers, marketing representatives, and psychiatrists,” Kalman Apilbaum (2006: 87) noted that “depression, anxiety, and related syndromes… are referred to as ‘diseases’ by most of my informants.” And, as Caplan (1996: 282) notes, training in DSM codes is now a mainstay of psychology programs, textbooks, and curricula.
the new DSM confined to the United States. As psychiatry’s flagship professional association, the APA had members from all across the globe, and non-American members soon found that they could gain access to Western sources of funding and professional prestige by basing their research on DSM terminologies. Translations were produced in thirteen languages (Coleman 2008: 349). The DSM-III’s “operational criteria, multiaxial classification and nomenclature [were] widely incorporated in the recent World Health Organisation classification ICD-10” (Haghighat 1994: 189) and the next edition of the International Classification of Diseases (ICD-11) was developed in close alignment with DSM coding systems (Meagher et al. 2008).

In the years following the DSM-III’s release, psychiatric treatment throughout Western nations was widely de-institutionalized and many wards were closed. Some writers have credited the mental patients’ liberation movements of the 1970s with this achievement, arguing that ex-patients’ efforts at raising awareness of the abysmal conditions in psychiatric wards and agitating for the dismantlement of the psychiatric system were ultimately heard and heeded in the 1980s (Everett 1994; see also Dain 1989). As we will see, the psychiatric inmate liberation/anti-psychiatry movements of this era did play a role in the emergence of “community psychiatry” treatment models, which indeed urged de-institutionalization. However, it is important to situate de-institutionalization within the neoliberal ideologies that emerged during this era. Such ideologies are “premised on using the norms of the free market as the organizing principles not only of economic life, but of the activities of the state itself and, even more profoundly, of the conduct of individuals” (Shore and Wright 2000: 61). That is, the neoliberal agent goes through life weighing risks and responsibilities, solidifying alliances, and calculating costs in pursuit of econometrically rational goals (Gershon 2011). This framework stresses a moral relationship between health, illness, and personal responsibility that “tends to assume a freedom to make healthy choices that is out of line with what many lay people experience as real possibilities in their everyday lives” (Williams 2004: 284). Under neoliberalism, public health campaigns deploy a “logic of privatised risk management” (Bell 2010: 350), whereby ill people have a duty to adhere to professional advice, make recommended lifestyle changes, take prescribed medication.

---

31 Access to funding and global recognition is not always quite so direct. When the DSM was introduced into the Argentinean mental health system, critics argued that it “was not a psychiatric nosology, but rather a catalogue for marketing psychopharmaceuticals” that was disreputably linked to deleterious transformations like “globalization, structural adjustment, and a lost common project of social modernity” (Lakoff 2005: 61). However, when an Argentinean public hospital signed a contract with a French biotechnology firm to collect blood samples from 200 patients with Bipolar Disorder in exchange for a $100,000 donation, staff psychiatrists began assigning this diagnosis to patients who might not have otherwise received it, in part because the hospital needed the funds.

32 Some examples of this dilemma will be detailed in chapter 6, section 3.2.
medications regularly, and follow nutritional regimens; and healthy people have a duty to prevent themselves from falling ill. To shirk any of these duties is to transgress the norms of good citizenship: falling ill and requiring hospitalization due to one’s own lack of foresight is to waste public money (see also Hoffman et al. 2006, Lupton 1995, Petersen and Lupton 1996, Rose and Novas 2005). Psychiatric de-institutionalization was therefore highly serviceable to cost-shifting ideologies that reassigned culpability for ill-health from public systems to private citizens, and that, in so doing, transformed psychiatry into a venture that, like colonial medicine, was more ideological than directly carceral. The infrastructural shifts that have driven this transformation are visible in three main sectors of modern healthcare provision—private industry, state services, and reimbursement systems—whose interests have converged in ways that anti-psychiatry activists likely did not anticipate:

1. **The conceptualization of DSM-III diagnoses as concrete “targets” for new drugs.** In 1962, following a public outcry over a tranquilizer (Thalidomide) that was linked to thousands of birth defects despite originally being proclaimed safe by its manufacturers, the United States Food and Drug Administration (FDA) initiated new regulations covering the pharmaceutical industry’s activities: prior to releasing newly designed compounds into the market, companies were now required to establish that they worked on specific medical diseases in randomized, controlled clinical trials (Coleman 2008: 348, Gellad and Lyles 2007). With the creation of the DSM-III, pharmaceutical firms now had a slate of well-defined diagnostic entities for which specific compounds could be marketed, and thus an elegant solution to the FDA’s regulatory pressures. Indeed, as Andrew Scull (2010: 1247) has noted, “soon enough the polarity would be reversed, and the creation of a new class of drugs would lead to the creation of a new psychiatric ‘disease’ to match, just one of the factors that prompted successive editions of the Diagnostic and Statistical Manual of Mental Disorders to proliferate pages and disorders.”

2. **Neoliberal reconfigurations of healthcare systems and other social services.** With the innovation of pharmaceutical compounds targeted (ostensibly) at specific mental illnesses, governments have increasingly legitimized cutbacks to social services by devolving responsibility for rehabilitation to individuals and their families. Beginning in the 1980s, emerging ideologies of state non-interference led to many hospital closures in North America and the United Kingdom on the logic that the “mentally ill” no longer represented a threat to the civic order so long as they remained medicated (Rose 2001: 20-24; see also Estroff 1992,
Scull 1984 on the fiscal rationales behind hospital closures. By the close of the 1990s, involuntary outpatient committal laws were in place in most of the United States, as well as in all Canadian jurisdictions (Ontario enacted these laws in 2000), which legally oblige outpatients to comply with pharmacological treatment plans on pain of forcible detention (Fabris 2011: 97-98, Healy 1997).

3. **Institutionalized incentives for clinicians to use DSM diagnoses.** According to Theodore Millon, one of the original members of the DSM-III revision task force, a major aim of the editors was to “embrace as many conditions as are commonly seen by practicing clinicians” in order to maximize the number of treatments for which patients could be reimbursed by third-party insurers and/or could use to secure disability pensions (Kutchins and Kirk 1997: 43). To this end, as many conditions as possible were itemized into DSM diagnoses. Whooley (2010) points out, however, that this has also had the effect of expanding psychiatrists’ access to insurance remittances, and therefore subtly incentivizing them to make more rather than fewer diagnoses.\(^{33}\)

The 900-page DSM-IV was published in 1994, with a text revision released in 2000.\(^{34}\) By this time, the biological specificity model of mental illness was firmly entrenched, underpinned by two interlinked premises: the notion that disordered behaviours are a “consequence of an identifiably, and potentially correctable, error or anomaly in some aspect of the brain, in its

---

\(^{33}\) The outcomes of this trend are not just financial. An American psychiatrist interviewed by Whooley (2010: 460; ellipsis in original) notes that “The DSM, since it’s accepted so widely by insurance companies, bureaucracies, it does have a big influence on whether the doctor or the institution gets paid or whether the patient will get disability or whether he will be excused, get compensation from if it it’s serious. So if you feel a person deserves to get compensation… you would have to have a serious diagnosis.” This explanation raises legitimate points. However, while “a serious diagnosis” of mental illness may serve the strategic aim of securing insurance coverage for a patient, it also has the effect of permanently marking their medical record in a way that may hurt their legal credibility, stigmatize them socially, eliminate their right to refuse subsequent treatments, or even change the way they conceptualize their own thoughts and feelings (Hacking 1999, Szmigiero 2009: 51).

\(^{34}\) Cosgrove et al. (2006) have revealed that 56% of the researchers who worked on the DSM-IV-TR (95 of 170) had at least one monetary relationship with a drug manufacturer between 1989 and 2004; 22% of these researchers received consulting income during this period; and 16% were paid spokespersons for a drug company. Up to 100% of contributors to the DSM-IV-TR’s subsections on psychotic disorders received income from pharmaceutical firms in the years around the manual’s release. The upshot of Cosgrove et al.’s study is not that “Big Pharma” is obliging researchers to falsify their data: commercial agendas can shape medical research priorities in less overt ways. For example, whistleblowers in the research community have provided firsthand accounts of companies’ efforts to get distinguished scholars to add their names to prewritten articles, to suppress reportage of negative clinical trial results, or to court scholars by sponsoring conferences and commissioning keynote lectures (see Healy 2006, Paris 2008). What is important is how difficult it has become to determine where the academy ends and the industry begins, especially in relation to the question of what qualifies as fundable health research and what there is to research in the first place.
neurotransmitters or receptors” (Rose 2003: 413) and the notion that “targeted drug treatment will restore the subject to a normal condition of cognition, affect or volition” (Lakoff 2005: 7). As Petryna and Kleinman (2006) note, the strength now enjoyed by the specificity model is underscored by the disproportionate growth of markets for psychotherapeutic drugs in recent years in comparison to markets for other drugs. In the United States, prescription rates of antidepressants increased 147.5% between 1990 and 1998 (Clarke and Gawley 2009: 91). In 2001, SSRI antidepressants, which were first marketed in the United States in 1988, accounted for over $9 billion in international sales per annum (Applbaum 2006: 87). Between 2002 and 2003, international sales of antipsychotics grew by 19% (Petryna and Kleinman 2006: 2); in 2005, antidepressants were the most prescribed drug in America (Whooley 2010: 466). Between 2007 and 2011, the number of atypical antipsychotic prescriptions filled at Canadian pharmacies rose from 772,000 ($38 million in revenues) to over 1.3 million ($54 million in revenues; Weeks 2012: para. 15). In a 2005 newsletter, former president of the American Psychiatric Association Stephen Sharfstein acknowledged that

The U.S. pharmaceutical industry is one of the most profitable industries in the history of the world, averaging a return of 17 percent on revenue over the last quarter century. Drug costs have been the most rapidly rising element in health care spending in recent years. Antidepressant medications rank third in pharmaceutical sales worldwide, with $13.4 billion in sales last year alone. This represents 4.2 percent of all pharmaceutical sales globally. Antipsychotic medications generated $6.5 billion in revenue. … As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model (Sharfstein 2005, quoted in Fabris 2011: 118-119; emphasis mine).

By the late 1990s, World Health Organization (WHO) researchers were reporting that unipolar depression was the second highest cause of disability in the world (Healy 2006: 65, citing Murray and Lopez 1996) and was projected to retain this ranking twenty-five years hence, ahead of road-traffic accidents and slightly behind heart disease (Murray and Lopez 1997: 1498, 1502). In its 2001 World Health Report, the WHO announced that psychiatric disorders had come to account for fully 12.3% of the global disease burden36 and 31% of the total number of “years lived with disability,” with mood disorders as the leading cause (Cohen et al. 2002: 1-2).

35 Atypical (“second generation”) antipsychotics are a class of tranquilizers prescribed for schizophrenia, bipolar disorder, and agitated states associated with anxiety disorders and impulse control disorders. Like typical (“first generation”) antipsychotics, atypicals diminish the reception of dopamine in users’ synaptic pathways, but allegedly without incurring akathisia and tardive dyskinesia (neurological disorders that manifest as involuntary muscular tremors). However, a growing body of evidence reveals striking similarities between both classes’ side effects, prompting the authors of a recent Lancet op-ed to contend that “the time has come to abandon the terms first-generation and second-generation antipsychotics, as they do not merit this distinction” (Tyrer and Kendall 2009: 5).

36 A measure of the social impact of illnesses based on projected mortality and morbidity rates, losses in economic productivity, and other factors linked to premature death.
Yet, as Ecks and Basu (2009: 87) have pointed out, “it seems odd that rates of depression should have multiplied by a factor of 1,000 since antidepressants were marketed.” And as Caplan (1996: 110) reminds us,

The events just described are cast in a useful perspective when we realize that fewer than two hundred people are listed as having been consulted in the production of the DSM-III-R—mostly psychiatrists, whites, and males—a small and limited group to have so much power to make pronouncements about normality and mental health and disorder.

2.3 The Pursuit of Happiness

Despite the economic incentives unlocked in the wake of the DSM-III, there is no doubt that the majority of mental health professionals do their work in good faith. It is also important to note that publicly traded companies are required by law to maximize shareholder value, and so the aggressive marketing efforts of drug manufacturers should not be seen as categorically different from those of other industries. However, as the above narrative illustrates, it is difficult to discuss the history of modern psychiatric institutions—or of psychiatrized populations—without discussing the cultural and political factors that primed their emergence. From beginning to end, core questions about the social function and scientific status of those who manage and minister to the “mad” have been at stake, guiding institutional norms, shaping research agendas, and reshaping public attitudes toward “mental illness.” These events have converged to yield a cultural field in which everyday life is increasingly managed through adjudications of mental capability, and mental capability or its absence are increasingly evaluated in “radically stripped down environments, in which very complicated things—life events, memories, dreams, existential states—are transmuted via diagnostic protocols, psychometric scales, and biological assays into standardised and commensurable artefacts” (Young 2004: 390; Rose 2001, 2004).

The 21st century conception of mental illnesses as specific psychochemical facts that can be dislodged with drugs raises compelling ethical questions when “the one who chooses the drug is not the one who consumes it, and the one who consumes it is not (or often is not) the one who pays for it” (Lakoff 2005: 139). Nonetheless, the mainstream public has largely been persuaded that “mild forms of psychological maladjustment as well as entirely normal psychological experiences” are appropriate objects for clinicians and prescribers (Herman 1996: 310) and people regularly comply with psychiatric reasoning even in the absence of coercive force, the threat of detention, or an actual psychiatrist. Indeed, Laurence Kirmayer (2002: 296) has noted the rise of a “cosmetic psychopharmacology” whereby cures are sought for unpleasant feelings “while our existential predicaments go unanswered,” and which has been accompanied by the emergence of new moralisms about the place of personal responsibility in civic life:
We may understand our behavior as chemically biased or determined and so claim we could not act otherwise. Alternatively, finding that a drug helps us, we may evaluate other people’s predicaments in these terms, wondering why they don’t simply take the drug to feel better (Kirmayer 2002: 312).

Despite the enormous stresses inherent to living in our society, public health campaigns and news reports consistently promote a view of “mental illness” as something foreign to the human body, which must be detected, managed, and, if possible, eradicated (see chapter 4). Overt or recalcitrant manifestations of anxiety, apathy, shyness, aggression, depression, and other forms of behavioural alterity become legible as symptoms of illness precisely because they transgress current cultural expectations about good conduct, even though “one cannot scientifically argue when suffering is legitimate and comprehensible as there are enormous differences between individual responses to misfortune and loss” (Szmigiero 2009: 51). Within this framework, mental health becomes more of a moral obligation than a biomedical norm or even a legal right, in the sense that “[p]eople are supposed to be in a positive mood except on some defined social occasions, such as mourning, and even then only for a limited period of time” (Hewitt et al. 2000: 174, quoted in Szmigiero 2009: 58). As Krantz (2001: 184-185) points out, in such a climate, psychopathological diagnoses are sometimes “selected or rejected as answers because they sustain social expectations and ideological needs rather than being ‘true’…” Research outcomes are thus used as ex post facto support for previously arrived-at answers.” In concert with these epistemic reconfigurations, companies have focused increasingly since the 1980s on enlarging markets by expanding the definition of what is considered treatable (Petryna and Kleinman 2006: 3; see also Gellad and Lyles 2007). In a sense, pharmaceutical firms “now sell diseases rather than just drugs” (Healy 2006: 82).

It is against a backdrop of seemingly widespread consensus about the nature of mental illness and widespread lack of discussion about the ideological and financial incentives that sustain this consensus—at least in mainstream channels—that ordinary people’s resistance to psychiatry must be understood. The circulation of pathologizing discourses in the mainstream media has had the dual effect of confirming popular fears and stigmas about a depoliticised,

---

37 This is literally true in Canada, where direct-to-consumer (DTC) drug advertisements are permitted to “either name the medical condition or the product, but not both,” a requirement that has encouraged many domestic marketers to elect the former approach (Hébert 2008: 119). Health Canada also turns a blind eye to DTC advertisements originating from the United States (e.g. aired on American television channels or printed in American magazines), which are permitted to name both product and condition (Hébert 2008). The naming of both product and condition in American DTC ads was legalized in 1997 with the passage of the FDA Modernization Act, which also removed the cap on the amount of money that drug companies could legally spend on DTC advertising each year. This enabled a tripling of DTC expenditures over the next four years and facilitated a 15% per annum increase in consumers’ drug expenditures over the next ten years (Arney and Rafalovich 2007: 50-51).
reified, targetable object called “mental illness” (what “it” is, what “it” does, what we should do about “it,” further explored in chapter 4) and angering those who are said to suffer from “it.” It is this anger to which we now turn.

3. The Fish and the Phoenix: Resisting Objectification

3.1 Dissidence in Motion

In the summer of 2003, a small group of psychiatric survivors convened in Pasadena, California, to hold a hunger strike with the aim of forcing the American Psychiatric Association and the National Alliance on Mental Illness (NAMI) to “produce even one study proving the common industry claim that mental illness is biologically-based” (Coleman 2008: 254; emphasis in original), as well as “evidence for a base-line standard of neurochemically balanced ‘normal’ personality against which a neurochemical ‘imbalance’ can be measured and corrected by pharmaceutical means” (Maddock and Maddock 2006: 96). At first, the APA was dismissive, and its medical director asserted that mental illnesses are “brain diseases and that this fact is as irrefutable as the ‘earth going around the sun’” (quoted in Coleman 2008: 355). Three weeks into the strike, however, the APA issued a statement conceding that

brain science… has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive biomarkers of a given mental disorder or mental disorders as a group (quoted in Coleman 2008: 343).

The APA never ended up presenting “even one” study to refute the protestors’ claims (Lewis 2006b). This episode raises interesting questions. In the United States, current laws require direct-to-consumer drug advertisements to acknowledge certain therapeutic risks and evidentiary uncertainties about the conditions they target (Gellad and Lyles 2007). However, professional associations of medical researchers and practitioners are under no such obligation. In addition, while it has become more common in the past ten years for individual psychiatrists to openly

---

38 The APA did, however, argue that psychiatric medications clearly influence patients’ neurochemistry and behaviours, and that some non-psychiatric conditions also lack biological markers and thus biological diagnostic tests (e.g. migraine headaches). In December 2003, a scientific advisory panel for the California hunger strikers issued a response to the APA, pointing out that “in other branches of medicine such disorders are exceptions. In psychiatry they are the norm. Psychiatry is the sole medical specialty that treats only disorders with no biological markers” (Baughman et al. 2003: 2). The advisory panel also pointed out that many illegal drugs also exert influence on users’ neurochemistry and behaviours, but this does not mean that they correct neurochemical imbalances. Citing the APA’s inability to offer decisive counterarguments or unambiguous biological evidence, the panel concluded its statement with a question: “on what basis does society justify the authority granted psychiatrists, as medical doctors, to force psychoactive drugs or electroconvulsive treatment upon unwilling individuals” (Baughman et al. 2003: 6)? One such basis will be explored in chapter 4.
critique their colleagues on the basis of evidentiary uncertainties,\textsuperscript{39} never before had a professional association of psychiatrists officially critiqued itself on this basis (Coleman 2008). The APA’s admission thus represented a rare and historic achievement on the part of psychiatric survivor activists, whose predecessors had long sought such an acknowledgement.

It is important to not romanticize the significance of this event. The APA’s acknowledgement has not had any material ramifications for psychiatric research directions, clinical treatment standards, laws based on psychiatric knowledge claims, or even the tenor of mainstream news reportage on mental health, which today tends to treat the biological specificity model as received wisdom. Indeed, the history of anti-psychiatric resistance in all of its names and permutations is replete with cases of direct action (everything from hunger strikes, demonstrations, and civil disobedience, to letter-writing and leafleting campaigns) in which resistors won specific concessions on the part of governmental watchdog bodies or legislators, which later went awry, or were reversed or simply ignored. For example, as we will see, a major objective of patients’ rights/liberation organizations throughout the late 1970s and 1980s was to force public mental health bodies in various jurisdictions to include patients on their advisory boards, and clinch “the power of negotiations, sitting at the table with professionals and policy makers” (Morrison 2005: 85). In many cases, this aim was achieved. However, it swiftly led to debates about the co-optation of former “radicals” by the salaries, prestige and awards they received in association with their new positions, and their perceived and/or demonstrated loss of interest in advancing the rights of others in the survivor community. Other examples are more concrete. In November 1982, psychiatric survivors in Berkeley, California, successfully lobbied for a public referendum on ECT, which resulted in a majority vote (62%) to establish a citywide ban on its use. The ban lasted forty-one days, before it was reversed by a judge on the basis that it violated patients’ “right to privacy” (\textit{Phoenix Rising} Editorial Collective 1983a: 14, \textit{PR}; see also Andre 2009: 285 and Cody 1991). In January 1984, the Toronto Board of Health called for a similar moratorium on ECT after listening to personal testimony from members of the Ontario Coalition to Stop Electroshock (OCSE) at a public meeting; however, the provincial government refused to support the moratorium, which therefore went unimplemented (Weitz 2007: para. 11).

\textsuperscript{39} For example, in a recent book that critiques his profession’s increasingly commercial influences, Joel Paris (a former Chair of McGill University’s Department of Psychiatry) wrote that “Our diagnoses are, at best, rough and ready, and do not deserve the status of categories in other specialties. We have no laboratory tests that can reliably identify any mental disorder, and the measures we use are entirely based on clinical observations” (2008: xiii). Paris’s overall argument is that his colleagues need to curb their preference for cheap and fast treatment methods (drugs) and reacquire expertise in more humanistic methods, like talk therapy and psychoanalysis.
Demands for governmental studies have also tended to go nowhere. Bonnie Burstow, who co-chaired the OCSE, has pointed out that

At various points, governments throughout the world, including Ontario and Quebec, have conducted investigations into the use of shock, generally at the behest of activists. The result was predictable: The press were initially excited and provided coverage. Time ticked by while the committee went about its research. The press lost interest and electroshock rapidly became a non-issue. When the report was finally released... it provided no hardhitting recommendations and utterly sidestepped the issue of gender. Moreover, for the most part, the recommendations were not acted on. What compounds the injury, for decades afterward, no one could interest the press anew, for they felt that they had already done justice to the ECT question. In the 1980s I, along with my colleagues in the Ontario Coalition to Stop Electroshock, made precisely that mistake, and the issue of electroshock in Ontario and most of Canada continues to be off the table as a result (Burstow 2006b: 120-121).

There are reasons in addition to those Burstow adduces for why today’s activists have such difficulty persuading the press to investigate major tools in the psychiatric repertoire, one of which is that neurophysical models of “mental illness” are even more hegemonic now than they were in the 1980s (Lakoff 2005; Martin 2007; Rose 2003), meaning that a larger percentage of active journalists have been socialized into the belief that psychiatric care is now safe, humane, and scientifically sound.\(^40\) However, her underlying point about how small victories can be serviceable to larger setbacks is important. As the primary literature from this era makes clear, and as my interviews corroborate, many erstwhile successes are seen in hindsight as failures, owing to a shift in resistance discourse from the liberation of inmates (chiefly from the 1960s through the early 1980s) to the participation of consumers (chiefly from the late 1980s to today).

Older ex-activists with whom I spoke frequently expressed disappointment or wistful resignation to the fact that “psychiatry,” however defined, now enjoys far greater societal influence, cultural prestige, and legal credibility than it did in the early decades of their activism. Although most no longer identified as activists, all continued to dissent from the mainline view that it is appropriate for psychiatrists to hold definitional and institutional prerogatives over patients’ bodies, choices, and lives. They expressed vivid disillusionment with the “consumerist” direction that their movement took beginning in the 1980s, and with their colleagues’ abandonment of Marxist, abolitionist, and other more “radical” lines of critique. My younger informants (aged 18 to 39), whose resistance to psychiatry assumed a wider range of guises

\(^{40}\) Additionally, as McElhinny (2003: 260) points out, “someone who has bought into a particular ideological view may not be dissuaded from it simply because arguments are presented which show that some of the assumptions upon which it is based are false, a fact that any teacher or political activist will need to take into account.” Mainstream journalists’ unwillingness to explore politically troubling questions about health and healthcare is at least partly attributable to the fact that such questions are inimical to cherished and widely held assumptions about our society’s democratic, meritocratic, and peaceful nature. Under these assumptions, news reportage will tend to focus on episodic rather than systemic vectors of ill-health, whose existence may not even be recognized (see also Bourgois 2009).
(some were proud activists, some fiercely denied being activists) were less prone to lamenting the rise of the “consumer” movement, but were more likely to point out the on-the-ground shortcomings of the “consumer” metaphor. This was also true of informants who were older than this age range but who did not develop anti-psychiatric viewpoints until relatively later in their adulthoods, and of parents of psychiatric survivors.

As I was frequently reminded during meetings of Unhinged and Acceptance, people who critique psychiatry on the grounds that it is legally accountable to its “consumers” make the mistake of assuming that doctors and patients enjoy the same level of credibility in the public eye. Discussions commonly alighted on the difficulty—or impossibility—of persuading friends, family members, and physicians that their medications were having adverse effects on them (“Just take your pills, you’re on ‘em for a reason”). In addition, participants routinely drew attention to how rare it is for psychiatric consumers to give genuinely “informed consent” in the psychiatric marketplace, given the widespread unavailability of information about the adverse effects of treatments and about the socio-historical, cultural, and economic dimensions of their day-to-day suffering (see chapter 6). When my informants spoke about their lives, moments of revelation were closely linked with the onset of a ferocious, politically charged anger, which did not end even if their activism came to an end. To some, the discovery that their doctors had been withholding information from them or their loved ones in order to ensure “med compliance” marked an irreversible turning point in their political orientations; to others, a gnawing sense that mainstream journalists had been shirking their investigative responsibilities was what sparked their political “awakening.” Either way, it eventually became impossible for most to identify as mere “clients” or “consumers.” As Deirdre put it, “I wasn’t consuming. I was consumed.”

To understand how these circumstances have arisen, we must first unpack the debates around identity, ideology, tactics, and ethics that unfolded in the pages of anti-psychiatric periodicals during the 1970s. We can then turn to the correlation between the DSM-III’s advancement of a new specificity model (which depicts psychiatric diagnoses as chemically targetable objects), the rise of the consumerism model (which depicts patients as clients being served by healthcare providers in a therapeutic marketplace and participating knowledgeably in their own care), and the debates about co-optation that raged in anti-psychiatric circles during the 1980s. In chapters 4 through 6, I will turn to exploring contemporary psychiatric survivors’ alienation from the political mainstream, and how corporate news outlets suppress alternative understandings of “mental illness” by advancing a dramatic narrative about the need to rescue
people from themselves, which contrasts sharply with survivors’ firsthand experiences of “illness,” “treatment,” and “recovery.”

3.2 Ends and Means I: Resistance in an Era of Resistance

Taped to a full-length mirror in the entryway to Malcolm’s apartment was a piece of paper—brittle, curling at the edges—on which the following lines had been scrawled in a thick, blue cursive:

An individual having unusual difficulties in coping with his environment struggles and kicks up the dust, as it were. I have used the figure of a fish caught on a hook: his gyrations must look peculiar to other fish that don’t understand the circumstances; but his splashes are not his affliction, they are his effort to get rid of his affliction and as every fisherman knows these efforts may succeed.

Karl Menninger

The musicians do their good deed,
take their bows,
collect their music,
tone-deaf to the screams
of the instruments
upon which they play.

Susan Packie

Malcolm, a Folie à Deux regular who was in his seventies, had a tendency to speak in a somewhat stream-of-consciousness manner, making him difficult to understand at times. In the early days of my fieldwork, I had asked him why he had selected these lines to erect in a place of prominence in his home, and he had dismissed the query with a shake of his head. “Right, right, it’s silly—I’m an old softie, I know,” he had mysteriously replied while lighting a cigarette. “Don’t hold it against me.” And, satisfied that he had answered my question, he launched into a slow, pensive soliloquy about free trade, Torontoian comedian Colin Mochrie, and the lack of Canadian content on television.

It was nearly a year before the meaning of Malcolm’s reply dawned on me. When I had first encountered his handwritten quotations, I had assumed that they had some thematic or motivational resonance with him, but it had not occurred to me that they might have wider significance within the history of organized anti-psychiatry. In the intervening months, I would discover that the first quotation was the epigraph of a seminal document known as the “Fish Manifesto” (officially titled, “The Need for a Mental Patients Union—Some Proposals,” and illustrated with an image of a fish thrashing on a line), which has been described as “the first link in an unbroken chain of ‘patient’ activism which leads through to the present day” (Crossley
2006: 144), “a timely reminder of where it is that the ‘survivor movement’ has come from” (Curtis et al. 2000: 23), and “an origin of anti-psychiatry” (Survivors’ History Group N.d.). First published in the early 1970s in West London, it was steeped in Marxist terminologies and served to launch the United Kingdom’s short-lived Mental Patients Union (MPU). In the 1980s, the MPU’s main successor organization, the Campaign Against Psychiatric Oppression (CAPO), disavowed the original manifesto in favour of a less stridently worded one in an effort to appeal to broader constituencies. I would also learn that the second quotation was the concluding stanza of a longer poem that appeared in the Winter 1983/1984 issue of the Madness Network News, whose coverage of the Berkeley electroshock referendum marked a major watershed in the history of American anti-psychiatry (“Berkeley’s Shock Ban Overturned,” see Figure 3.1 in Appendix II). The MNN would last only six more issues, each of which would increasingly feature debates about co-optation by the capitalist system and anxieties about the future—and effectiveness—of resistance.

As I learned more about the fragmentation and collapse of 1980s anti-psychiatry, it struck me that Malcolm had been under the impression that I was already familiar with the two quotations’ origins and had perhaps assumed that my question was a subtle jab at his affection for the symbols of a defunct movement. When, in another conversation, I asked him about his years as a member of a communist youth group, he brought the underlying issue into sharp relief.

Everything ends. Everything. It’s easy for young people, young people of today to laugh. To laugh. You have to imagine. We were all communists. It’s not like it is now. Even guys who didn’t ((long pause)) Even if you weren’t in anti-psychiatry, you got the issues. Fundamentally it was the same. When it ended, it was both in one go. … You can’t be radical ((long pause)) you couldn’t be radical if you didn’t get all the issues. Psychiatry ((turns one palm up)) Capitalism ((turns the other palm up, pauses, then claps both hands together)). Not like now.

Even if (anti-)psychiatry and (anti-)capitalism are not necessarily prerequisites of each other, the equivalence that Malcolm drew between them highlights a common theme in political activism: the members, tactics, and rhetorics of contemporaneous movements often overlap and/or mirror each other, allowing groups with similar ideological predispositions to shore up credibility with one another, but also (at times) obliging them to rise and fall in unison. To understand how this theme has played out for resistors of psychiatry, it is necessary to backtrack a bit.

There have been few studies of anti-psychiatric social movements to date, and even less research on the thriving underground anti-psychiatric press of the 1970s and 1980s. Most of the primary historical material from the 1960s through the 1980s is now very scarce, and secondary historical accounts tend to be focused on a specific region (e.g. Crossley 2004, 2006 on the United Kingdom; Maddock and Maddock 2006 on Ireland) or focused solely on resistance to a
specific psychiatric treatment (e.g. Andre 2009 on the history of anti-ECT organizing in the United States). The challenges of finding historical material on North American grassroots anti-psychiatry movements become clearer when we consider that only two book-length studies of such movements currently exist: Nick Crossley’s *Contesting Psychiatry* (2006) and Linda Morrison’s *Talking Back to Psychiatry* (2005). Because *Contesting Psychiatry* focuses on the United Kingdom, neither *Madness Network News* nor *Phoenix Rising* were mentioned in its pages. In contrast, Morrison does analyze some early volumes of *MNN* in *Talking Back to Psychiatry*, which is a history of American C/S/X activism, but her coverage of *Phoenix Rising* is confined to a single sentence in which an advertisement for the magazine is said to “provide evidence of continuing radical activities in Canada” (Morrison 2005: 83).

The above observations are not criticisms of Crossley’s and Morrison’s studies. In light of their respective geographic foci, these omissions are neither analytic shortcomings nor unique to their work. Indeed, with the exception of Morrison, even authors who do mention North American anti-psychiatry’s flagship journal—the *Madness Network News*—do not analyze its internal content, almost certainly due to the unavailability of back issues (e.g. Andre 2009; Chamberlin 1990; Coleman 2008; Dain 1989, 1994; Tomes 2006). Yet, Crossley’s findings, Morrison’s findings, and my own findings overlap in important ways, as major trends and tactics in anti-psychiatric countercultures throughout the West—on both sides of the Atlantic and both sides of the 49th parallel—have tended to arise from, feed into, or reflect those of contemporaneous countercultures on the Left: Marxism, feminism, prison abolition, disability rights, queer rights, and so on. In addition, because psychiatrists have long participated in internationalized research projects and paradigms, it is not surprising that the people subjected to their interventions would develop similar critiques at similar moments. As one survivor-activist discovered on a trip through Europe in the early 1980s, “a lot of people had no idea that other liberation groups existed outside of their countries [and yet] their publications all carried similar graphics, poetry, articles, and slogans” (Boldt and Nihera 1985: 48, *PR*). And, as an American activist who traveled to the United Kingdom in 1979 put it,

I spent a very pleasant afternoon and evening rapping with them [MPU organizers whom he had run into] about the movements in our two countries. After an hour or so it felt as if I was among old friends. It’s hard to reproduce the flavor of this conversation, but I remember that about every five minutes I found myself saying, “That’s the same kind of thing we’re doing in the States,” or being told, “That’s the same problem we had here” (Chabasinski 1979: 11, *MNN*).

While the term “anti-psychiatry” was first coined by the South African psychoanalyst David Cooper in his 1967 book *Psychiatry and Anti-Psychiatry*, oppositional attitudes had
already been gathering steam for several years, due to the public’s expanding awareness and decreasing tolerance of egregious abuses in psychiatric wards. Everett (1994) points out that the increased psychiatrization of middle-class populations during the 1950s meant that former inpatients now had the communicative and financial resources to publicize their experiences and demand change. Like other radical movements that arose during the 1960s, it was on university campuses and amongst educated, relatively privileged constituencies that “anti-psychiatry” first emerged, engaged with public audiences, and proposed alternatives. Most historical accounts of anti-psychiatry begin by reciting the names of a handful of prominent scholars, all white, male, and European or American: Michel Foucault in France, R.D. Laing in the United Kingdom, Erving Goffman and Thomas Szasz in the United States, and Franco Basaglia in Italy (Chamberlin 1978, Coleman 2008, Crossley 2006, Dain 1989, Morrison 2005, Rissmiller and Rissmiller 2006). In his 1960 book The Divided Self, Laing argued that psychoses and delusions were not medical symptoms but understandable reactions to inescapable, persecutory social orders. The book became a bestseller on American and British college campuses, and, with the help of his students, Laing founded a controversial network of “therapeutic communities” throughout England, wherein patients and staff ostensibly “assumed equal status and any medication used was voluntary” (Rissmiller and Rissmiller 2006: 864). As Crossley (2006: 101) put it, owning a book by Laing at this time “would have been as sure a sign of radicalism as a book by Marx or Trotsky, and would have been virtually de rigueur for a trendy lefty.”

Forcible detention was the main target of writers who became associated with organized anti-psychiatry during the 1960s, whether or not they themselves identified with the term. In 1961, the psychiatrist Thomas Szasz published his influential book The Myth of Mental Illness, which contended that because there is no demonstrable biophysical basis to what are called mental disorders, these disorders must simply be deviations from accepted moral and behavioural norms. Szasz, whom the editors of the Madness Network News Reader credited with having “played a very important role in the growing revolt against psychiatric control” (Hirsch et al. 1974: 75, MNN Reader), argued that the forcible detention of the “mentally ill” was indefensible in any society that claims to value individual freedoms, and, while psychiatric hospitals enhance the status of a medical elite, they do little to aid individuals in distress. At

---

41 Szasz later clarified that he also opposes the forcible eviction of inpatients who have adapted to life in mental institutions, asserting that “once he has been in for a long time, when that’s his only home, I’d give him a choice about whether he wants to stay or not” (1979: 73) and that forcible eviction has the effect of “depriving the ‘mental patient’ of a predictable and stable environment both within and without the insane asylum” (1990: 562). His clarifications may have been motivated by the backlash he received in the wake of deinstitutionalization, when it became clear that decarcerated patients had few or no community supports to which to turn (see Scull 1984).
around the same time, Erving Goffman’s landmark study *Asylums* (1961) revealed how mental institutions socialize patients into becoming passive receptacles of treatment, which in turn reinforces stereotypes about the chronic nature of mental illness. Michel Foucault’s *Madness and Civilization* (published in French as *Histoire de la Folie* in 1961 and translated into English in 1965) explored the social construction of madness from the Medieval era through the end of the 18th century, revealing the ease with which objects of knowledge can become objects of disciplinary interventions. In 1964, Franco Basaglia presented an influential report at the First International Congress of Social Psychiatry, observing that “The psychiatrist of today seems to have discovered, suddenly, that the first step towards the cure of the patient is his return to liberty of which, until now, the psychiatrist himself had deprived him” (1964: 1). Like Goffman, Basaglia argued that the psychiatric ward itself was pathogenic:

Crossley (2006: 124) has noted that the popularity that anti-psychiatric arguments enjoyed at this time “benefited from the existence of critical publics ready to receive their ‘sort’ of ideas.” The antiwar and civil rights movements were in full ferment by the mid-1960s, and the emergence of leftwing journals such as *New Left Review* (1960–) and *New Society* (1962-1988) allowed critics of psychiatry to access readerships already sensitized to structural inequities and iniquities at home and abroad. Indeed, during this period, “activists and academics alike seized the concept of madness as a means by which to understand the very nature of social injustice, inequality, and political interventions” (Coleman 2008: 344), one famous example of which was Martin Luther King’s 1963 declaration that “I am proud to be maladjusted… I say very honestly that I never intend to become adjusted to segregation and discrimination… I never intend to adjust myself to economic conditions that will take necessities from the many to give luxuries to the few” (King 2005 [1963]: para. 44). However, because 1960s anti-psychiatry was largely premised on critiques of asylums and largely articulated by and for middle-class, male spokesmen, it came under a two-pronged attack in the 1970s. The increased prominence of second-wave feminist and anti-colonial movements turned the floodlights on problems of representation within anti-psychiatry, and attentions began to shift away from the critiques of philosophers, sociologists,
and even (or especially) dissident psychiatrists and toward the critiques of actual patients. Patients began to notice that the academic treatment of psychiatry “as a monolithic knowledge/power system… denies the agency of those whose lives are lived in, around, through, and in opposition to, psychiatric diagnoses and treatments” (Knowles 1996: 103).

Former patients began to convene in collectives with the official agenda of closing down psychiatric systems rather than merely reforming them, and of forming mutual support networks and “safe houses” for former inpatients (Morrison 2005). Among the first such collectives were the Insane Liberation Front in Portland, Oregon (1970), followed by the Mental Patients Liberation Front in Boston (1971), the Mental Patients Liberation Project in New York City (1971), the Soteria House project in San Jose (1971), the Vancouver Mental Patients Association (1970), the Mental Patients Union in the United Kingdom (1971), and the Network Against Psychiatric Assault in San Francisco (1972) (Coleman 2008: 345, Curtis et al. 2000, Maddock and Maddock 2006: 108, Shimrat 1997: 51). Dozens of smaller groups emerged as well, and, although most comprised only a handful of members and had short lifespans, they soon drew the attention of the U.S. Presidential Commission on Mental Health, whose 1978 report noted that “groups composed of individuals with mental or emotional problems are in existence or are being formed all over the United States,” albeit without mentioning their politically dissident character (quoted in Chamberlin 1990: 329).

It was in this climate that the two major pillars of 1970s-1980s North American anti-psychiatric activism were founded. The Madness Network News (subtitled “All the Fits that’s News to Print,” see Figure 3.2 in Appendix II), which was first published in 1972; and the Conference on Human Rights and Psychiatric Oppression, which was first held in Detroit in July 1973 (Morrison 2005: 72; these conferences would be held annually in different North American cities until 1985). In its first year, the MNN had a circulation of 800, mostly localized in the San Francisco Bay Area; however, within two years, its circulation would reach 5,000, with many readers based in Canada and Europe (Hirsch et al. 1974: 11, MNN Reader). Using the Conference and the MNN as organizing tools, former patients staged massive demonstrations outside psychiatric hospitals and occupations of politicians’ offices—often in collaboration with other groups similarly invested in putting a stop to certain forms of psychiatrization. In May 1970, “hundreds in the antipsychiatry movement joined gay activists in forming a human chain barring psychiatrists from entering the American Psychiatric Association’s 124th annual meeting” and, during a similar protest in 1971, “gay activist Frank Kameny grabbed the podium and declared war on psychiatry for its DSM classification of homosexuality as a psychiatric
disorder” (Rissmiller and Rissmiller 2006: 864). Anti-psychiatry activists’ efforts at forging coalitions with other movements reflected a recognition that their interests were not only shared, but were in some respects identical. The *MNN* ridiculed the pathologization of sexual diversity in a regular feature called “No Comment Dept.,” which ran excerpts from mainstream newspapers in which prominent clinicians expressed homophobic views (e.g. “If I smelled my sons wearing perfume, I’d feel like I failed them as a father … Homosexuality is a form of psychopathology,” quoting a senior psychology professor, *MNN* 1978: 24). Using the parlance of the 1970s prison abolition movement, ex-patients began calling themselves “ex-inmates” and advocating greater solidarity between the two constituencies, pointing out that prisoners and mental patients are both kept in “correctional institutions” (Beasley 1974: 41, *MNN Reader*) and are both subjected to forcible medication (Temkin 1979, *MNN*).

Despite these ecumenical efforts, both the *MNN* and the Conference discouraged and eventually disallowed contributions from people who had not been psychiatrically incarcerated. It was announced in *Madness Network News* (“Movement Notes,” 1978: 6) that, “As decided at the 1977 conference, attendance this year will be limited to current and former ‘mental patients’ and non-‘patient’ anti-psychiatry activists who are endorsed by the ex-‘patient’ organization closest to them.” As Judi Chamberlin (1990: 325) put it,

> There are several reasons why the movement has grown in this direction—a direction which began to develop in the early 1970s, influenced by the black, women’s and gay liberation movements. Among the major organizing principles of these movements were self-definition and self-determination. Black people felt that white people could not understand their experiences; women felt similarly about men; homosexuals similarly about heterosexuals. As these groups evolved, they moved from defining themselves to setting their own priorities. To mental patients who began to organize, these principles seemed equally valid … It seemed sensible, therefore, to not let non-patients into ex-patient organizations or to permit them to dictate an organization’s goals.

In particular, Chamberlin (1990: 325) notes that “groups that did not exclude non-patients from membership almost always quickly dropped their liberation aspects and became reformist.” Ana, who was not active in patient liberationism during the 1970s but who described herself as having been “active around it, very near it” in the burgeoning disability rights movement, similarly framed the problem as one of tactics rather than merely ethics. In her eyes,

---

42 In the late 1960s, “disability” came to signify a distinct axis of identity around which legal and civil rights accrued, a time period that coincided with the rise of psychiatric patient liberationism. Although disability rights activists initially modeled their movement on the 1950s-1960s civil rights movement (Shapiro 1993), they also sought to “demedicalize” disability in a manner similar to the psychiatric liberationists, framing it as “less as a matter of abnormal species characteristics requiring treatment or cure than as a fluid combination of social stigmata, living arrangements, and legal remedies” (Bérubé 2005: 88).
There’s nothing immoral with letting non-survivors into a survivor-run group. But let’s recall. What are the goals? What are the chances someone who’s never been in the system is going to want it abolished? Will they know why it’s [psychiatry’s] wrong? Will they work for what’s right if it starts to hurt [i.e. to incur personal or professional risks]?

Questions of dedication converged with questions of authority. For the first time, having firsthand experience as a mental patient signalled that one possessed greater rather than less insight into the nature of one’s condition (Tomes 2006: 722), and being (mis)treated within the psychiatric system became a type of symbolic capital that marked one’s voice as both authoritative and authentic (Crossley 2004: 167; see also Gabriel 2004). Alé, who lived in San Francisco at this time, following his release from a local hospital in which he had been diagnosed with a “schizophrenic reaction,”43 situated the problem as a levelling of the playing field:

I got so angry one time. What about Szasz—as you know, so many of us were influenced by him, his, his brilliant analysis in, in Myth. What if he came out and wanted a say? … But, looking back, it was right [to restrict membership]. Cause you saw what happened in the eighties, all the co-optation. Well. No, of course you didn’t. Well, a lot of survivors were on SSI and disability, but they came out, hitchhiked, to have a voice, and you wanna make them share the stage? (pause) You’re a big college prof, you have a voice. (pause) Well. There was a lot of disagreement, as you know, comradely disagreement. Should we apply for grants? Should we take money from the state?

As Alé indicates, controversies swirled not only around questions of identity and membership, but around questions of funding and the problems of accepting money from suspect sources. Like most other underground newspapers of the era (Ellis 1971: 114), the Madness Network News was sustained mainly by subscription revenues and classified ads that sufficed to cover production and postal costs but did not allow for salaries (Chamberlin 1990: 327). The annual Conference was also sustained mainly by donations and volunteers, and on multiple occasions its organizers had to announce in MNN that a certain year’s conference might be cancelled if funds continued to dry up. Because the pool of potential conferees consisted primarily of ex-inmates on social security, each year’s steering committee wrestled with the question of whether to solicit grants “to subsidize room and board costs” for attendees (Frideley 1978: 15). In 1979, readers were reminded that,

The financial and work burden of this important and international conference falls on one group, the local group that is sponsoring it. … Please make this conference a reality, for we need funds to make it happen. The liberation of mental patients is the task of the patients themselves. So we ask that ex-“patients” and our supporters support our task by donating to [this address] (Mental Patients’ Rights Association 1979: 2, MNN).

43 He did not learn of this diagnosis until years after his release, when he requested access to his medical records. While in the hospital, the medical staff rarely spoke directly to him (“Nobody told me anything. Nada. Why I was there, what you’re [they’re] going to do to me”).
One former activist (male, aged 69) whom I reached by email linked these debates to a need to avoid compromising readers’ trust in the independent media at a time when most journalistic outputs were already considered problematic. The *Madness Network News*, he said,

was our Monthly Review [an independent socialist journal founded in 1949]. You know, it’s the 70s. The Washington Post goes, the Democrats are the lesser of the evils. And Review goes, yes, which means they’re evil. Yes, a nicer prison is still a prison … You could take it for granted Madness had solid politics: they weren’t in the purse of big business or government. But if they’d been, you’d have to wonder. How worried are they about losing the grant… what are they running or not running to keep it? (second ellipsis in original)

As we will see, financial need was a major factor in the widespread collapse and dissolution of psychiatric inmate liberation networks in the 1980s. However, it is important not to underestimate the role of epistemological rifts that developed toward the end of the 1970s, which fall into two main categories: debates about what objectives/demands to pursue, and debates about what reasoning to deploy in pursuit of these objectives (or, as one informant put it, debates about “ideological correctness”). Within the first category (demands), the achievements of the 1970s patient/inmate liberationists were in some respects multitudinous. Until the late 1960s, legal statutes throughout the United States deprived mental patients of the right to vote, marry, and hold professional licenses once they entered an institution, and required them to perform mandatory, unpaid work on hospital wards (Brown 1985; Rosenhan 1973). As well, statutes that authorized police officers to forcibly hospitalize “dangerous” people did not define the parameters by which “danger” should be identified, meaning that “arbitrary interpretations can be used against anyone whose behavior upsets the status quo—a political activist, a rebellious child, a woman who refuses to function in the roles set up by society” (Fridely 1978: 15). Patient liberationist groups capitalized on these legal ambiguities with a torrent of malpractice lawsuits. Each *MNN* issue featured a double-page spread entitled “Legislation & Litigation” that listed brief updates on dozens of legal battles, class action claims, and key rulings that were taking place all across the continent (see Figure 3.3 in Appendix I). A major function of the *MNN* was to “give people information about their rights and the points of leverage which they can apply to gain more rights” (Hirsch et al. 1974: 173, *MNN Reader*), and, to this end, it contributed significantly to improving the terms and conditions by which people enter into psychiatric systems in North America. By the end of the 1970s, inpatients were no longer automatically stripped of their civil rights, mandatory labour on wards was made illegal, sanitary and aesthetic conditions were improved, most jurisdictions had introduced concrete criteria for determining what behaviours justified involuntary detention, and some states gave

However, these legal victories smuggled in certain vulnerabilities, not the least of which was that many movement actors felt that they had served to strengthen rather than undermine the legitimacy of institutional psychiatry. One former activist’s (male, aged 69) formulation of the problem in an email to me (“They sold out justice for pie and a weekly phone call”) reminded me of a line from a piece in the MNN Reader that was, somewhat ironically, directed at psychiatrists rather than activists (“You deprive us of love and give us candy and bingo,” Kolocotronis 1974: 148, MNN Reader; see Figure 3.4 in Appendix II). Moreover, even where statutes safeguarding certain forms of voluntarism were instituted, it was, in practice, still the case that people who refused to consent to treatment were declared “incapable” and treated anyway (as an informant put it, “Here’s something about consent—if you can’t say no, you can’t say yes”). Given that most liberationist groups’ original aims were to abolish and not to reform psychiatry, feelings of ambivalence and betrayal contributed to the disillusionment and demobilization of some core members; other members demobilized because they thought they had succeeding in enhancing patients’ rights within psychiatric systems and “were comforted by the fact that the worst forms of segregation, inequity, and mental health abuse were over, for many had been fixed in the law books” (Coleman 2008: 357; see also Chamberlin 1990: 332-333).

The sundering effects of debates in the second category (“ideological correctness”) must be understood in the context of these legal battles. In order to assert a unified political voice in pursuit of legal reforms, individuals who had experienced a heterogeneous range of difficulties and life events had to assign themselves a collective identity. However, whether this identity category comprised “psychiatric ex-patients” or “ex-inmates,” the biographic diversity that underlay anti-psychiatric discourse was still masked by the movement’s predominantly white, male, middle-class spokespeople (Dain 1989: 10). Reporting on the 11th Annual Conference on Human Rights and Psychiatric Oppression (19-24 May 1983, Syracuse University), one conferee lamented that “So far, our Movement has failed to attract black people and other people of

---

44 As MNN Reader co-editor Robert Roth argued in a Californian law journal, additional shortcomings of legal safeguards include their pro forma quality and their narrow focus on the moment of commitment. The fact that patients have a right to request legal representation does not prevent clinicians from interpreting such requests as evidence of paranoia; the fact that the legal onus is on doctors to prove that patients are “mentally ill,” rather than on patients to prove they are not, does not prevent judges from accepting the opinions of doctors more readily than those of patients; and the fact that a psychiatric history does not vitiate a person’s right to employment cannot prevent potential employers from declining to hire the person on other pretexts (Roth et al. 1973).
colour” (Weitz 1983: 14, *PR*). Describing the 6th Annual Conference (27-30 May 1978, Bryn Mawr College) in the feminist newsmagazine *Off Our Backs*, one participant wrote,

A number of people were working class but there were no Black and few Third World participants. ... As a lesbian attending a mixed conference I had qualms, and a few were justified. There is the question of dealing with men whose reason for being institutionalized might have been attacks on women. Heterosexual men inevitably play on the weaknesses of heterosexual women, and this is particularly destructive when the woman is vulnerable from being institutionalized. There are few all-women groups active in the MPLM [Mental Patients’ Liberation Movement]. I know of only two [but] neither group is composed totally of ex-inmates (Fridely 1978: 15).

Movement actors regularly debated these representational inequities, which largely persist to the present day. As Morrison (2005: 78) notes, the psychiatric survivor activists who have achieved “the levels of highest visibility” on the American political stage have, for thirty years, been almost uniformly white, although more “evenly split by gender” in administrative contexts: for example, the editorial mastheads of each issue of *Madness Network News* routinely included slightly more women than men. Indeed, many women ex-inmates felt alienated from mainstream feminisms that embraced the concept of “feminist therapy,” and, weary of submitting to others’ diagnoses, defined their anti-psychiatry in contradistinction with such feminisms:

The antipsychiatry movement excludes professionals for many of the same reasons most women’s groups exclude men. For most ex-inmates, the “professionals” (including “radical” or “feminist” therapists) are the oppressors—they are the individuals who determine what behavior is “sick” and should be “treated.” (Fridely 1978: 15)

Out of loneliness and total lack of support, I decided to get into counseling at a local feminist therapy group recently. Even at the start, I felt this was an inadequate solution to the problem of needing an ex-inmates’ support group, which is not available. I decided that isolation was preferable to the type of “support” I was getting from her. I quit this destructive relationship about two weeks ago, and my main regret is that my present situation is so isolated that I even consider these types of solutions. ... I hope to contribute an article in the coming months, probably on the topic of how patronizing I find the treatment I receive from people even in radical and feminist culture (House 1981: 32, *MNN*).

Similar sentiments persisted well into the 1980s, with some writers expressing disappointment with the feminist community’s perceived unwillingness to take seriously the gendered dimensions of psychiatrization. The below excerpt echoes an observation that Olivia (of the survivor peer support group Unhinged) made to me on many occasions: that women’s shelters and rape crisis centres have been co-opted by mental health ideologies, and they were therefore, in her eyes, “unsafe spaces” where unsuspecting users could be suspected of mental illness, urged to seek treatment, and ensnared thereby into a life of on-and-off psychiatrization. Although Olivia firmly identified as a feminist, she was, like the below writers, emphatic that most other feminists had very little insight into psychiatric survivors’ experiences.

---

45 The question of why anti-psychiatry movements tend to consist overwhelmingly of white participants will be revisited later in this thesis (chapter 7).
The majority of women ex-inmates in the Mad Movement… feel little solidarity with the U.S. feminist movement. As a whole, U.S. feminists have refused to take a position against the medicalization of undesirable behavior, electroshock, forced treatment or medical incarceration. It is not uncommon for a woman to land in a cage through the direct efforts of “sisters” (Boldt and Nihera 1985: 48, PR, writing about the 12th Annual Conference on Human Rights and Psychiatric Oppression).

Socioeconomic inequalities also pervaded the psychiatric inmates’ liberation movement. Alé, who attended one of the annual Conferences in the 1970s, identified the structure of the Conference as inherently classist: “Don’t get me wrong, but so much was, let’s have hours of talky meetings where everyone talks, and guys who talk for a living—you know, college guys—outtalk everyone else.” As he put it, middle-class activists would commandeering panels and plenary sessions to give advice to working-class or poor conferees, whose remarkable urban survival skills were trivialized or criminalized (“they would kind of go, don’t talk about that sort of thing here”), allowing those with superior rhetorical skills and professional qualifications to emerge as “natural candidates” for liaising with the media and, in general, to become “the face of the movement.”

Debates about the construction of a pan-movement identity were further complicated by the messiness that underlay people’s categorical identifications with one school of thought versus another. Many people who explicitly distanced themselves from the term antipsychiatry were nonetheless anti-psychiatry in the literal sense of advocating the total dismantlement of psychiatric systems. On the other hand, people who did identify as antipsychiatry activists did not necessarily advocate an abolitionist agenda, and many expressly distanced themselves from it. One informant (female, aged 63) framed the problem as a jurisdictional struggle: “A lot of it was wanting to be my own person… not in a group where to be anti-this you have to be anti-that. I wanted to come into my own conclusions… I was always more anti-psychiatry than most of the VIPs [prominent activists] and the crowds around them. But I wouldn’t use the word.”

Interestingly, this informant’s valorization of individualism over collectivism is reversed in the below excerpt from an early issue of Phoenix Rising that identifies a very similar concern:

North America has developed… individual charismatic personalities operating on their own with a small group of devoted followers. The effectiveness of these individuals (such as Toronto’s Pat Capponi) is mixed; they are very effective at commanding media attention, but often represent a highly individualized perspective rather than a democratically arrived at collective viewpoint (Starkman, PR 1981: 4A).

While the influence of the U.K. Mental Patients Union was limited in North America due to geographic distance and the fact that most of its “cells” had died out by the mid-1970s (Crossley 46).

46 A Torontonian psychiatric survivor (b. 1949) known for her consultative work with social agencies and hospitals and her many books about poverty in Canada and life as a former inpatient. Her advocacy career earned her an Order of Ontario in 1993.
2006: 157), its own attempts at policing its members’ identities is worth discussing in brief, if only because its Marxist theoretical frame has been revived in some North American Mad Pride/Mad activism circles. Like its North American counterparts, the MPU restricted its membership to people with firsthand experiences within mental health infrastructures and urged solidarity with “Trade Unions, Claimants Unions, Women’s Liberation, Black Panther Groups, Prisoners’ Rights, etc” (Irwin et al. 2000 [1972]: 26). However, in so doing, it explicitly made the more class-oriented anti-psychiatry of the 1960s an object of derision and contradistinction.

Consider the below excerpts from the Fish Manifesto:

In the past few years a number of groups have sprung up in opposition to the reactionary institutions of the mental hospital and psychiatry. Ignoring patient involvement, the impetus of these groups’ radical alternatives, however, have become little more than intellectual discussion points and shop-talk for students and professionals … Almost colluding with the myth that mental patients are ‘inadequate,’ these groups have dismissed completely the fact that patients, of whom most are working class, together with hospital workers and nurses, are the only agents of revolutionary change inside the mental hospital … The Union will be organised and controlled only by mental patients and ex-patients. The union membership and voting rights will be limited to patients alone (Irwin et al. 2000 [1972]: 23, 28).

Despite the MPU’s rejection of the class elitism that its members discerned in the previous decade’s dissident circles, “MPU activists continued to reference anti-psychiatric writing positively in their own writing, thereby acknowledging the influence of the anti-psychiatrists upon them,” and many MPU publications contained reading lists comprising titles authored by Laing, Szasz, Goffman, and many others firmly positioned outside of the working class (Crossley 2006: 148). Ex-inmates’ newsletters in North America similarly included reading lists that prominently featured titles authored by non-inmates (“Mad Librarian” was the MNN’s heading for these lists, signifying that although these books had not been authored by a “mad” person, they had at least been endorsed by one; see Figure 3.5 in Appendix II).

The identity debates of the late 1970s were anchored in a fundamental, underlying question: to what extent should “the” movement target the social and cultural forces that lead to people’s psychiatrization and to what extent should it maintain a narrower focus on psychiatrized people’s rights and well-being? Movement actors approached this problem in various ways:

I believe not enough attention is being given to psychology. I used to think the psychologists were just the unwitting dupes of the psychiatrists, but when you examine their role in the present school system, from Elementary School right through to the universities, you can see that they are in the positions to do great damage on a long-range basis. They instill their theories in students that then form the basis for the widespread use of over-drugging, shock and psychosurgery. The average citizen then goes along with it because he has been taught all through school that these are normal and necessary procedures. So, while the psychiatrists actually cut up brains, shock people, and administer crippling drugs, the psychologist paves the way for the whole system. I would like to see more mention of this in your paper (Louis 1978: 5, MNN).
He was not a victim of psychiatric oppression, just of a fucked-up society that does not encourage people to explore what it is that hurts so much in their lives and to get that pain out in a supportive, loving environment (Gotch 1978: 4, MNN).

In an exchange between readers that took place in the pages of MNN in late 1978 and early 1979, the question of what it is that movement actors should target, why, and how they should go about it, became even more explicit. Consider the following excerpt from the second contribution to this exchange, which appeared under the heading “Where Do We Go From Here?”

This is a rambling reply to Sally Zinman [whose article appeared in an MNN issue that unfortunately I do not have access to]. She suggests that there is not a lot of need to concentrate movement efforts on exposing and fighting the sexism, racism, capitalism, or authoritarianism that permeate our society. (And, to some extent, psychiatric inmate groups.) The amelioration of the physical, emotional, and economic suffering of psychiatric inmates and former inmates must be our only concern, according to Sally.

... But most of us, Sally, were being broken down by social conditions in our personal lives before psychiatry identified us as “deviants.” Returning to those lives (trying to reconstruct them) has placed many of us back in the frying pan—back in living situations in which we are lonely, poor, treated with no respect, and denied decent food, housing, work, and companionship. Racial and sexual discrimination are additional burdens for many of us—they are daily realities, not abstract political ideas. The economy of welfare capitalism rewards the rich with profits and the poor with menial, low-paying jobs, or unemployment and just enough money to barely survive. (And yet TV advertisers expect us to equate happiness with consumer goods, frozen nutrient-free foods, and expensive “culture”—so-called “entertainment” and “art.”) Psychiatry expects us to be grateful for drugs and shock and interrogation (“therapy.”) The rich expect us to be grateful for welfare and SSI, SRO hotels and board-and-care homes, and TV dinners. Women, gays, and blacks are supposed to be glad they are treated like human beings sometimes; the lawmakers might even get around to making it legal to complain about sexual discrimination in the future.

... we must remember that to make any real changes, fundamental changes—like shutting down psychiatric institutions—we need sympathetic, informed support from non-inmates. We are beginning to realize that it’s a waste of energy trying to talk to “liberal” shrinks—those who feel that only “really psychotic” people should forcibly drugged, for example. Who are our natural allies, our necessary allies if we hope to win against psychiatry? I think we should look to others who are being beaten down by the system—poor people, blacks, the elderly, the gay and lesbian communities, and, of course, women (Latz 1979: 5, MNN; underlining in original; boldfaced emphases mine).

The writer’s emphasis on the socioeconomic stressors that lead to psychiatrization maps closely onto Allan Young’s influential 1982 insight that a cardinal function of medical anthropology must be “not merely to consider the meanings that individuals attribute to sickness but also to lay bare how societal relations produce the forms and distributions of sickness characteristic of any given society” (Lock 2001: 479, on Young 1982). The above letter of course does not refer to anthropology but to anti-psychiatry, which in many ways was undergoing a philosophical crisis similar to the ones that academic fields routinely undergo. Unlike academic fields, however, social movements typically lack institutional homes, and the fact and form of their continued existence may thus rely more immediately on participants’ tactical responses to these crises (Kingdon 2003, Meyer 2002). If psychiatrization is an understandable endpoint of living in a racist, heterosexist, and capitalist society, it may seem natural for anti-psychiatry activists to link up with “others who are being beaten down by the system,” but it does not necessarily follow
that those others will concur that “shutting down psychiatric institutions” is a desirable goal. On the other hand, working to improve the situation of psychiatric inmates and ex-inmates to the exclusion of all others may create, to quote Cassidy, “a political ghetto… you win some rights and fine, but you still haven’t shown them [non-inmates] your interests are theirs too.” Implicit to these debates is the question of educational strategy, which must be understood in light of McElhinny’s (2003: 256) observation that hegemonic power relations are embedded in “signs and material practices, relations and distinctions, ideas and epistemologies that are so powerful they become taken-for-granted, and thus no longer appear as ideology at all… The moments its internal contradictions are revealed, negotiable, contested, then hegemony becomes ideology.” Because it is difficult to sway policymakers or the electorate without first swaying “prevailing mainstream attitudes” (Patton 2005: 224), political activism routinely requires extensive efforts to revert hegemony to ideology in the public eye—to reveal the contradictions and constructedness of power relations that previously seemed normal, natural, commonsensical.

The correct question would then seem to be: how, when, and where are these efforts best directed? But this, too, presents a problem. Although no one is immune to hegemony—not academics, not activists—the way its contours are inhabited differs from person to person. What is comfortably commonsensical to some people may be dishearteningly commonsensical to others, and the same norms and narratives that confer moral status upon one class of people can compel others to loathe and blame themselves (Fanon 1963, 1967; Bourgois 2003). The soundness of a tactical or political argument will therefore rely on the lived experiences of the person assessing the argument: something that is intuitively persuasive to one person will be dubious to another, an insight that sparks revelation in one person will fall flat with another, and people’s conclusions will accordingly differ. Apolitical people can become militantly politicized for many different reasons, some of which will inevitably conflict, and the need to persuade policymakers that a movement “speaks with one voice and truly represents the preferences of its members” may help to clinch certain practical goals while also alienating a plurality of members (Kingdon 2003: 52; see also chapters 6 and 7). For this reason, social movements are notorious for proliferating splinter groups and “niche” offshoots as soon as irreconcilable differences in the main community emerge, which, as we will see, is precisely what happened to anti-psychiatric constituencies in the 1980s, including the MNN editorial collective itself.

This brings us to a final point of contention discernible in the debates of the 1970s. For the first time in the three-hundred-year history of modern psychiatry, patients were collectively mobilizing not to deny that they were mad or deviant—the strategy of 18th and 19th century
“alleged lunatics” like Elizabeth Packard—but to assert that so-called madness and deviance were legitimate points on the behavioural spectrum that allowed greater insight into the human experience. On the one hand, the new focus on valorizing madness allowed ex-patients to subvert/invert the psychiatric system’s definitions of morality and intelligence, as illustrated in the opening lines of a poem printed in a 1973 *MNN* issue and reprinted in the 1974 *Madness Network News Reader*:

I saw the second best minds of my generation
    destroyed by sanity
  fattened untouchable clothed
tapping down the whitened streets at 9 a.m.
pushing toward a drably murderous job
  or down an aisle to a ringed enslavement
Only the finest went mad
  cut pretty little paper dolls out of their wrists
followed whispering voices down the silent city at dawn
walked up to the policeman and politely inquired if they
might borrow their gun to shoot themselves with
  rode the subways all night to shake the strange
man who was following them whose face kept changing
  hot wired trucks to escape from the place which there wasn’t
enough gas in any truck to escape from
  went days and nights and nights and days without
sleep because they could never again sleep alone
(David 1974 [1973]: 156, *MNN Reader*; emphases mine)

In his initial five lines, the author parodies the opening verse of Allen Ginsburg’s famous poem, *Howl*, which begins, “I saw the best minds of my generation destroyed by madness, starving hysterical naked, dragging themselves through the negro streets at dawn looking for an angry fix” (1984 [1956]: lines 1-4). By accepting Ginsburg’s designation of “madness” as a defining trait of “the best minds of my generation,” David makes a corollary of this designation explicit: those untouched by madness would be, at most, “the second best minds” of that generation, who, “destroyed by sanity,” can only comply with stultifying social imperatives like working nine-to-five jobs. On the other hand, some readers felt that the focus on identifying with madness (rather than with sanity) undermined efforts to expose the internal irrationalities of psychiatric healthcare systems and undermined the credibility of “mad liberationists” who sought to critique the pseudo-scientificity of psychiatry. As one Letter to the Editor asserted,

I am just now rather quickly going through one of your publications of MNN. It was sent to me by my friend… Both of us realize that we must attack these psychiatrists with scientific proof—emotionalism can only do us harm. … Twice in 1976 I found myself in mental hospitals because I had had a seizure. This is where my research [on epilepsy] came in handy for when I had sufficiently recovered I literally, verbally attacked the shrinks. They could not possibly answer me—for I have facts—statistics—etc.—they have theories. Needless to say I was discharged posthaste. … As a nurse I know the only way to fight them is with provable data (Armstrong 1978: 5, *MNN*).
Two observers, reflecting on the “mad liberation” strategy in hindsight, advanced similar views:

If the public sees you as crazy, and you go ((screams)) ‘Yeah, baby, I am crazy! Ugh! Ugh!’, who’s that going to help? … I said it a hundred times. You want people to take you seriously, you have to take yourself seriously. People like Elizabeth Packard would have gotten nowhere with that [identifying as mad], and, frankly, neither did we. … Part of the reason I left was, I wanted nothing to do with this, like this granola stuff. Okay? You’re mad—fine—[therefore] you [other activists] got locked up. That is not what happened to me. … By no means was I mad, okay? (former activist, female, aged 63).

Rosenhan’s study [see section 2.3 on David Rosenhan’s 1973 pseudopatient study] was a gift. It fell into their laps, and they said, ‘Ew, a scientist wrote it.’ … You know, why should it be a surprise? ((pause)) Insane Liberation? ((pause)) To people on the street, that’s terrifying. What they should have done is gone, ‘No no, look, being institutionalized for nothing happens to everyone, could happen to anyone—you too.’ (Cassidy)

These critiques bring to mind Emily Robertson’s (2007 [2000]: 448-449) positioning of “practices of rational persuasion as the social ground in which the normative concept of rationality is rooted,” as well as Umberto Eco’s insight that “the problem affects us not only at the level of learned debate, but also in daily behavior and political life” (quoted in Robertson 2007 [2000]: 449). In other words, criticisms of sanity—and valorizations of madness—must themselves satisfy certain standards of rational argument if they are to be persuasive. At the same time, it is important to acknowledge that “Such criticism may be best seen not as a repudiation of reason but rather as an attempt to reclaim emotion and imagination as important to intelligent thinking” (Lloyd 2005: 300). Indeed, if political awakening consists in becoming sensitized to the multiple, subtle ways in which ideologies appear commonsensical, enduring the social stigmata of psychiatrization can considerably enhance one’s understanding of society’s normative values and the power relations that sustain them. Suffering can and does incite curiosity, rage, critical thinking, indignation, and the motivation to learn more about the historical and political determinants of one’s suffering (see chapter 6). In this context, explicit reclamations of “madness” can draw attention to how polite placeholders (“mental illness”) mask disturbing and alienating realities that cause people to go “mad,” and they can suggest alternative interpretative frameworks (see Bérubé 2005 for more on the political value of resignifying pejorative terminologies). As a major player in the United Kingdom’s Coalition Against Psychiatric Oppression (the main successor group to the MPU) put it, “You can’t change the whole of society with a poem, but if you can help someone to understand things a little more and they go away and think and talk to a friend, you start to help change attitudes and break barriers down” (Bangay 2000: 101).

I want to reiterate that the internal controversies and inconsistencies that permeated 1970s anti-psychiatric movements are not aberrant: all communities, and indeed all people, exhibit...
internal conflicts and inconsistencies.\footnote{Also, despite my focus on internal rifts, it would be remiss of me not to mention that \textit{MNN}’s pages were replete with letters from grateful readers who described the newspaper as their sole lifeline to a community where they felt understood, and where the violence of psychiatry, the injustice of preventive detention, and the constructedness of “mental illness” were accepted premises. As one reader put it, “Keep publishing. You’re important to me. …If they eventually put me away, just knowing that \textit{Madness Network News} was still out there would give me strength. Keep speaking out” (Vitti 1983/1984: 32, \textit{MNN}). In the words of another, “\textit{MNN} needs to thrive: it is our sustenance and I can’t express how rewarding it has been to be a subscriber” (Crancer 1983/1984: 32, \textit{MNN}). And as another reader asserted in \textit{MNN}’s final issue, “Your journal, which I discovered last year through a synchronistic fluke of luck, has really helped me in the healing process. I truly thought I was alone in my belief that the psychiatric system is brutal and harmful” (Sanbower 1986: 4, \textit{MNN}).} What is crucial about the above narrative is how the rifts that emerged around questions of \textit{identity} (who gets represented and who erased?), \textit{objectives} (what are the proximate and ultimate goals, do they undermine each other, and how should these efforts be funded?), \textit{strategy} (what’s the best way to persuade the public and achieve concrete change?), and \textit{ideology} (are ethics being compromised in favour of tactics?) made anti-psychiatry vulnerable to dramatic changes in the international political and biomedical landscape that took place beginning in the mid-1980s. By demanding legal reforms in the understandable interest of enhancing patients’ rights and living conditions, groups created a demand for rhetorically skilled, media-savvy ex-patients who could serve on hospital advisory boards as consultants: this would soon lead to the professionalization of some forms of activism/advocacy, and the marginalization of other forms. By focusing on the need to abolish mental institutions and ban particularly violent procedures, groups effectively endorsed the neoliberal downscaling of publicly funded healthcare systems and paved the way for new pharmaceutical compounds to be marketed as more humane and more specific, and for DSM-III psychiatry to seem like a genuine step forward. Finally, as Patton (2005: 225) has noted, “Because the new social movements based their claims on the essential qualities of the oppressed—their race, sex, sexuality, regional experience, religion, age grouping—they could be continually bogged down in debates about who expressed the most correct version of a labeled social experience.” By eliding the diversity within anti-psychiatry communities with the catchall collective identity “psychiatric ex-inmate/ex-patient,” and rigorously policing membership using this criterion, groups formalized an identity category that would increasingly exclude many psychiatrized people over the next three decades (e.g. people who had never been hospitalized but had taken medications, as well as the “undiagnosed mad,” a category whose racialized and classed dimensions will be discussed at greater length in chapter 7) to the satisfaction of some, and to the despair of others.
3.3 Ends and Means II: The Shifting Terrain

3.3.1 Medical Consumerism Gains Traction

When I was first gaining entry to Acceptance, Sylvie was on her way out. Her departure was marked with no overt acrimony; she remained close friends with at least one other regular participant, and no one ever spoke ill of her during the year I spent with the group. However, when I caught up with her to inquire about her reasons for leaving, she was blunt. Although Acceptance was full of well-intentioned, loving family members of psychiatric patients, and although she liked and respected them all, she was the only member who had had firsthand experience as a psychiatric inpatient. As a former inpatient, she felt that could no longer put up with the “sanism” that she discerned in many of their discussions: the structuring assumption that people with a psychiatric history are, as a group, less able to know their own lives and their own best interests, to achieve independence, and to live safely beyond the purview of institutional or familial supervision. “It’s not stigma,” she said, almost spitting the last word. “It’s bigotry.”

Sylvie, who was now in her fifties, had been institutionalized against her will in the 1980s, when she was attending college in the United States. While bicycling home one day, she hit a pothole and tumbled headfirst into the pavement. To protect her face, she raised her arms so that they would take the brunt of the impact, and she twisted a wrist. “The pain was unbearable,” she said. Her doctor prescribed a tranquilizer. Over the ensuing weeks, the throbbing in her arm did not seem to abate. When she returned to the doctor’s office insisting on a stronger prescription, he refused to provide one and replied that the throbbing must have been psychosomatic (“all in my head”). The throbbing did not subside over time. Sylvie’s father, who was a friend of her doctor’s, eventually colluded with a psychiatrist with whom they were acquainted to have her committed for what they assured her would be a short period of observation. This ended up being eight weeks of verbal and physical abuse by hospital personnel, four-point restraints, and regular doses of the antipsychotic medication Thorazine (chlorpromazine), which made her feel “dull—just mentally dull, very, very dull.” She considered herself fortunate, in that she was ultimately able to earn her release by “playing the

---

48 The Acceptance member I call “Jared” had also been psychiatrized, as he had spent a number of years taking antidepressants and resenting their adverse effects. However, he did not consider himself a person with a psychiatric history, did not identify as a psychiatric survivor, and was always careful to point out that he was in the group in support of his fiancée Deirdre, who suffered from panic disorders. Once, when I asked him why he did not see himself as a “psych survivor,” he replied that doing so would risk insulting “real” survivors, a population he defined only as “the ones who’ve been through a lot more [than he had],” whether as inpatients or outpatients. In addition to his evident wish to respect the singular traumas of such individuals, Jared may not have wanted to claim an identity that was both potentially stigmatizing (code for former “mental patient”) and laden with political baggage.
game,” obeying the doctors’ orders and behaving compliantly. She was acutely aware, however, that the label “former mental patient” would accompany her for the rest of her life. “Why should I,” as she put it, “get called incapable, just for being in the wrong place at the wrong time? What difference does it make, that someone’s been in or out of hospital, or on or off a drug?”

Sylvie’s yearlong stint as an Acceptance regular had been motivated by her own son’s diagnosis of clinical depression. She had mainly been interested in learning about the strategies that other parents used to encourage their similarly diagnosed children (mostly teenagers and young adults) to achieve pragmatic goals such as completing a high school or college diploma, applying for jobs, performing basic hygienic tasks, or simply “doing something.” In practice, the group’s main focus was less on sharing strategies than on how participants felt, coped with, and philosophized about the difficulties in their lives. And so, although Sylvie herself was interested in restoring the “capability” of her son, she took issue with an unseemly undertone that she detected in meetings, i.e. other parents’ apparent insistence that their children’s lack of “capability” generalized onto all other psychiatrized people, including herself.

When I alluded to Sylvie’s grievances at a Folie à Deux meeting, Ana’s eyes lit up. “That lady knows her roots,” she observed, zeroing in on the one aspect of the story that most interested her: Sylvie’s depiction of problematic attitudes about psychiatric survivors as a form of “bigotry” rather than simply “stigma.” Perhaps noting a look of uncertainty on my face, Sheila helpfully added,

Have you read Judi Chamberlin’s book yet? It’s seminal. The problem with this thing is we don’t have institutions. We’ve got to have a way to keep these basic ideas in currency—like, bigotry, you’ve never heard of this, the two-tier society that we live in? … We need a way for the young people, the younger generation to not keep having to—you know, reinventing the wheel.

The book to which Sheila referred was Chamberlin’s 1978 On Our Own: Patient-Controlled Alternatives to the Mental Health System, which critiqued psychiatric institutions for harming patients (not necessarily abusing them, but demoralizing them by controlling all facets of their daily life) and advocated alternative communities (“services”) in which participants could recover from urgent existential pain in safe, affordable, mutually supportive environments. While Chamberlin did not use the word “bigotry,” her concluding argument was indeed that former

---

49 “Sanism” is a controversial construction among psychiatrized people who are subject to other forms of marginality. The organized survivor movement in Canada is predominantly white, and non-white survivors are sometimes reluctant to give “sanism” the same status as “racism” (or to call it “bigotry,” which tends to refer to racist or sexual intolerance in common usage, despite its broader dictionary definition). After all, anyone can become psychiatrized, and a psychiatric survivor can often hide her medical history when it is socially advantageous to do so. However, a white person cannot become non-white, nor can a non-white person pretend to be white when whiteness is beneficial. This point will be revisited in chapter 7.
mental patients face a sort of binary prejudice within mainstream society, wherein clear distinctions between those with a psychiatric history and those without are encoded everywhere (e.g. newspapers often report that a murderer or rapist has a psychiatric history, as “ex-mental patient is a code word for a violent, dangerous, unpredictable individual,” but the same newspapers virtually never report that the president-elect of an organization or recipient of a prestigious award has a psychiatric history, Chamberlin 1978: 202). At the same time, Chamberlin’s book also laid the foundation for a vocabulary that many survivors—including Ana, Sheila, and Sylvie—lament and eschew today, namely the treatment of consumer preference as a placeholder for choice. To be clear, Chamberlin did not coin the “consumer” identity label. Even though she is widely credited with originating the notion that patients should be entitled to make certain decisions about their care, to “be active, knowledgeable participants in dealing with their problems,” and to hold psychiatrists responsible for the “effectiveness” of their services (Dain 1989: 10; Rissmiller and Rissmiller 2006), Chamberlin’s express wish was to provide options to people who want them, not to oblige people to choose from among them whether they like it or not. Nonetheless, the roots of a consumerist paradigm are evident in the words she selects:

In alternative facilities, to which these people will come willingly since they are troubled and are seeking help, there is no deadening institutional routine, no naked exercise of power. If they do not find the help that is provided satisfactory, clients can make demands that things be changed (demands that must be taken seriously in a true alternative), or they can leave and find another source of help. Facilities that clients find unsatisfactory must change or go out of business, since (unlike mental institutions) their clients are always free to leave.

And what of the other group of mental hospital inmates, those who are there against their will, who do not view themselves as needing help? What would happen to them in a truly voluntary, noncoercive mental health system? Obviously, they would not come to alternative facilities, since they don’t think they have problems and aren’t looking for any help. My answer is simple, although it will not satisfy those who believe that psychiatric diagnoses justify involuntary detention for purposes of “treatment.” People who are believed by others to be “mentally ill,” who do not themselves want treatment, should be free to live their lives as they choose, unless they commit crimes (which statistics show is unlikely). … People who talk to themselves, dress oddly, don’t eat right, or display other psychiatric “symptoms” are not criminals (Chamberlin 1978: 212-213; emphases mine).

Chamberlin was a major lobbyist on the American patients’ rights scene during the 1970s and 1980s, and the reputation she acquired in the United States led both the New York Times and Boston Globe to publish obituaries following her death in January 2010, which memorialized her “writings about the dehumanizing treatment inside mental hospitals” (Lawrence 2010: B14) and her “leading role in the movement to guarantee basic human rights to psychiatric patients” (Hevesi 2010: A28). Chamberlin’s impact on the Canadian iteration of the anti-psychiatry movement was also profound, as On Our Own inspired the renaming of Ontario’s first association of psychiatric survivors—from “Ontario Mental Patients’ Association” in 1977, to

The first myth—and an important one with respect to the relationship between “mental patients” and the community—is the myth that “mental patients” are dangerous and violent people. I think the newspapers and the other media are largely responsible for this. I’d like you to think back to the last time you saw the words “mental patient” or “psychiatric patient” in a newspaper. What were they coupled with? It was probably “Mental Patient Kills Child”… “Mental Patient Beats Up Wife”… “Mental Patient Drives Car Into Telephone Pole”. When is the last time—to steal a line from Judi Chamberlin’s book “On Our Own”—that you saw a headline that read “Mental Patient Elected Head of House and Garden Club”? When I graduate from law school next year, is there going to be a headline that says “Mental Patient Graduates From Law School”? … Now there have been a number of studies done on relative rates of violence. Every single study that has ever been done has shown that the rate of violence among people who have been in mental hospitals is lower than among the general population—anywhere from two to fourteen times as low (McKague 1979: 2-3, PR; underlining and first two ellipses in original).

While this insight raises valuable questions about the news media’s role in advancing dubious stereotypes about “mental illness,” it also contains the seeds of the anti-stigma campaigns of the late 1980s that, in the eyes of some survivors, undermined the idea that psychiatrization was continuous with other forms of marginalization. For example, although it is true that “mental patients” tend to be unfairly stigmatized as “dangerous,” many people receive those two labels in the reverse order—they commit a criminalized act, and forensic psychiatrists then saddle them with diagnoses that supposedly capture their psychopathological motives. One survivor, a non-activist and former Phoenix Rising reader (female, aged 59) who held a generally positive opinion of the magazine, thus argued that

It’s not [that] mental patients rarely commit crimes. It’s, you commit a crime, they slap you with a mental label. See how it’s reversed? And who’s committing crimes? It’s—you know, when you’re in need. Look at prison populations—very, very racialized. When they say, “Blacks are more likely to be imprisoned,” the logic is reversed. So, same thing. Of course they go, ’Everyone in prison’s mentally ill,’ cause going to prison means they’re going to give you a diagnosis. So, this thing about, you know, needing to show the achievements of ex-patients—or, or, saying patients need more rights—they do, but don’t hack at the surface. It’s the ones who haven’t been labelled—they’re the ones ((waves her hand at other people in the coffeehouse))—you know, they have shitty lives, they’re really, really being screwed over. ((pause)) But haven’t fallen prey to the system yet. You have to show their suffering is real ((taps the table twice)). It has a context. It doesn’t deserve to be called medical, trivialized, and you have to stop it from happening.

As this informant alludes, there is an epistemological problem with Chamberlin’s and McKague’s invocation of “mental patienthood” as a monolithic subject identity that can be de-
stigmatized through, essentially, publicity campaigns that play up the accomplishments of former patients. Namely, such campaigns gloss over a distinct form of psychiatrization that historically has been the burden of racialized populations (e.g. the pathologization of anti-colonial resistance as “neurosis” or “fanaticism,” Fanon 1965, McCulloch 1995; the pathologization of African Americans’ Civil Rights activism as “hostility” or “aggression,” Metzl 2010). More broadly, anti-stigma campaigns tend to rely on a superficial we/you dichotomy that not only turns a blind eye to the pain of those “who haven’t been labelled” and “haven’t fallen prey to the system yet,” but minimizes the existential and psychological travails of non-mental patients. Due in part to the impact of these paradigms, potential opportunities for inter-movement and inter-community collaboration (of the kind that John Latz advocated, see section 3.2) were arguably lost in the 1980s, as anti-psychiatry movements became more, rather than less, fixated on we/you debates.

The story of *Phoenix Rising*—or “The Phoenix,” as Malcolm affectionately called it—illustrates some of ways in which this preoccupation played out. The magazine was given its name by law student and ECT survivor Carla McKague, and its first editorial collective consisted of three women and two men. All of the editing was undertaken in a two-bedroom apartment in Toronto on the basis of a $5,600 grant from Ontario PLURA (Presbyterian, Lutheran, United, Roman Catholic, Anglican), a multi-denominational church group that provided start-up funds for grassroots organizations (*Phoenix Rising* Editorial Collective 1980b: 3-4, *PR*). According to former editor Irit Shimrat (1997: 40), “On the *Phoenix* editorial collective, there was absolute consensus that psychiatry had to be abolished.” Don Weitz describes *Phoenix* as

> the most political ex-inmates' publication ever to come out in Canada. And I’d like to say this about it: if I were starting a magazine again, I would not want it to be published by an organization. A lot of people in *On Our Own* resented the strong tone of *Phoenix*. They said it was strident and too antipsychiatry. Well, that’s too bad. We’ve all been there; we’ve all been oppressed (quoted in Shimrat 1997: 51).

The first issue was published in 1979, although the official inaugural issue was published in March 1980 (see Figure 3.6 in Appendix II). In the latter, *Phoenix* was introduced as “a rallying point for inmates and ex-inmates who want to bring about changes in the ‘mental health’ system that is all too often damaging rather than helpful” (*Phoenix Rising* Editorial Collective 1980a: 2, *PR*). Regular features included “Phoenix Pharmacy,” which detailed the adverse effects of commonly prescribed psychiatric drugs; “Profiles” of notable activists and groups; “Rights and Wrongs,” which was similar to the *MNN*’s “Legislation & Litigation” section; and “Giving Them the Bird,” which in each issue named one person “who has in our opinion made a courageous and significant contribution to bettering the lot of psychiatric patients” and one person “who has shown outstanding lack of understanding of the position of psychiatric inmates, or has
contributed to making their situation worse” (Phoenix Rising Editorial Collective 1980c: 4, PR; see Figures 3.7 and 3.8 in Appendix II). Other content included book reviews, interviews, news items, cartoons, and personal testimonies (see Figures 3.9 and 3.10 in Appendix II). Many issues were devoted to specific themes: for example, the psychiatrization of women, of gays and lesbians, of the elderly, and of the homeless, and uninvestigated deaths in psychiatric wards. The magazine’s editorial collective was especially attuned to the socioeconomic challenges that led to institutionalizable madness responses; although authors did not typically employ Marxian terminologies or the language of class conflict, many issues focused heavily on the link between economic injustices and mental health problems (see Figure 3.11 in Appendix II). While its Letters to the Editor page (entitled, “Write On”) soon became a reliable forum for heated debate, Phoenix Rising, like its American counterpart, received many grateful letters from psychiatric inmates and ex-inmates who saw the magazine as a philosophical lifeline. As one early subscriber noted, “It seems that every time I begin to feel a little down, I receive the next issue of Phoenix Rising and my mood gets an uplift” (Genereaux 1981: 28, PR). As another reader put it, Phoenix Rising is excellent. I’ve heard so much and been around so long I thought I’d seen it all. But knowing about these treatments is one thing, to put together a magazine as effective as yours is devastating. It left me in awe. In all the years of my incarceration I haven’t felt anything—I felt everything in Phoenix Rising (Smith 1985: 3-4, PR, emphasis in original).

This quotation exemplifies certain themes that will reappear in later chapters: a deeply held conviction that firsthand experiences of psychiatrized hardship confer unique forms of wisdom (“I thought I’d seen it all”), the reception of an alternative media outlet as a source of transformative insight (“a magazine as effective as yours… left me in awe”), and the identification of a sharp contrast between the diminished interior lives of chronic inpatients (“In all the years of my incarceration I haven’t felt anything”) and the sudden exhilaration of discovering anti-psychiatric politics and discourses (“I felt everything in Phoenix Rising”).

In 1982, many Phoenix members helped to organize and host the 10th Annual Conference on Human Rights and Psychiatric Oppression (14-18 May, Innis College, University of Toronto), which was scheduled to coincide with the date of the American Psychiatric Association’s annual meeting, also held in Toronto. Conferees at the former staged energetic protests outside the venue of the latter, the Toronto Sheraton, an undertaking described by one of my informants (female, aged 59) as the anti-psychiatry community’s “last hurrah.” At the entrance to the Sheraton, protestors chanted, “They say we are crazy, they say we’re insane / But we don’t make

50 As one Canadian survivor who was politically active in the 1980s reminisced to me, “No one who lived that era forgets Phoenix Rising.”
atom bombs or acid rain” (Oaks 1982: 10, *PR*; see Figures 3.12 and 3.13 in Appendix II). To shed light on the irrationalities of their society, protestors again linked their critiques to broader political movements on the Left, which during the 1980s focused extensively on nuclear disarmament and environmental policy (Kazin 2011; Meyer 1990, 2004). In the Innis College courtyard, the conferees devised and ratified a Declaration of Principles consisting of thirty statements affirming (among other things) an opposition to “the medical model of ‘mental illness’ because it justifies involuntary psychiatric intervention,” an opposition to “the use of psychiatric terms because they substitute jargon for plain English and are fundamentally stigmatizing,” a belief that “the psychiatric system cannot be reformed but must be abolished,” and a belief that

voluntary networks of community alternatives to the psychiatric system should be widely encouraged and supported. Alternatives such as self-help or mutual support groups, advocacy/rights groups, co-op houses, crisis centers and drop-ins should be controlled by the users themselves to serve their needs, while ensuring their freedom, dignity and self-respect (Tenth Annual Conference on Human Rights and Psychiatric Oppression 1982: 40, *PR*).

The Declaration then concluded with the resolution, “We intend to make these words real and will not rest until we do” (1982: 40, *PR*; see Figure 3.14 in Appendix II). Indeed, *Phoenix* and other publications placed tremendous emphasis on showcasing self-help groups and advocating alternative services. Like their American counterparts, *Phoenix* writers also stressed the need for solidarity between prisoners and psychiatric inmates, asserting that “We are not ‘patients.’ We share with our brothers and sisters in prison the experience of being an *inmate*: loss of freedom, loss of civil and human rights, loss of control over our own bodies and minds, and stigmatization for life” (*Phoenix Rising* Editorial Collective 1980d: 3, *PR*; emphasis in original). However, the anti-psychiatry community’s continual valorization of “self-help” groups in the wake of Chamberlin’s *On Our Own* began to destabilize the “inmate” analogy. As a discursive move, the focus on facilitating “self-help” and “alternatives” was meant to demonstrate that activists acknowledged and cared about those who would have nowhere to turn if psychiatry were instantly abolished. As Crossley (2006: 131) has noted, the “power of psychiatry rests in part upon the fact that distressed individuals and their families need help… Insofar as psychiatry has a monopoly on providing solutions for these problems, it is clearly in a very strong position.” By contesting that monopoly, anti-psychiatry activists were deploying the logic of a “rational choice” business model that was stacked against them—a central problem faced by many psychiatrized people is precisely that they are predefined as *irrational* and disqualified from
exercising choice. Nonetheless, the prospect of enhancing the therapeutic marketplace was understandably attractive to *Phoenix* readers. As one 1982 Letter to the Editor asserted,

> I add my voice to those readers who object to the term “inmate.” If O.O.O. [On Our Own] is truly committed to constructive change in Ontario’s Mental Health Institutional Services, the use of the term “inmate” prevents many in all sectors of society from joining the Coalition on Psychiatric Services’ efforts to improve services. The term is destructive not constructive! (Tickle 1982: 6, PR)

The writer’s emphasis on the need to avoid divisiveness in order to clinch service improvements must be understood against the changing political landscape of the 1980s. At the same time that *Phoenix* was rising, other international anti-psychiatric movements were on the wane. Scholars have generally attributed the decline of American anti-psychiatry/psychiatric inmates’ liberationism to three factors. First, the reservoir of public sympathy that was available to 1970s anti-psychiatry organizers “derived from its close relationship to other progressive leftist coalitions that, by association and overlapping membership, supported the movement” (Rissmiller and Rissmiller 2006: 865). With the rise of Reaganite and Thatcherite ideologies during the 1980s and the decline of the radical left, anti-psychiatry activists could no longer rely on countercultural sympathies (see also Dain 1989, 1994; Morrison 2005). Second, ex-inmates’ legal grievances were for the most part being addressed with new statutes providing for the rights of psychiatric patients, meaning that moderate constituencies within these movements began to demobilize, and that as opportunities for involvement on advisory committees grew many ex-patients “had alternative and in some ways more rewarding options open to them than conventional protest” (Crossley 2006: 191; see also Everett 1994, Morrison 2005). Third, the problem of funding came to a head in the early 1980s, with some groups finally accepting grants from state health ministries. Many self-help services of precisely the kind advocated by Chamberlin began to accept funding from the U.S. National Institute of Mental Health (Bluebird 2004: 46; Tomes 2006; see also Chamberlin 1990 for her own criticisms of this development), while others adamantly rejected state sponsorship and soon withered away. However, not every group that sought state funding received it: groups that employed a language of “consumer” empowerment and focused on alternative therapies (e.g. artwork, talk therapy) tended to receive grants, while groups with more politically militant agendas did not (Andre 2009: 16; Bangay 2000: 103).

There is no doubt that the fragmentation of anti-psychiatric networks in the 1980s can be explicated in terms of the above factors. However, it is important to also consider the serviceability of the “self-help” and “alternative service provider” concepts to neoliberal healthcare ideologies, especially in light of a renewal of public faith in biological psychiatry that
was occurring at that time. Despite the fact that the DSM-III’s release in 1980 was accompanied by numerous “splashy stories in the press,” and that “TV news magazines showcased several of the newly identified disorders” (Spiegel 2005: 62; see also Kutchins and Kirk 1997; Whooley 2010), neither *Madness Network News* nor *Phoenix Rising* paid any substantive attention to the manual or its content. Both journals focused, as they always had, on denouncing especially brutal or graphic psychiatric procedures; on publicizing survivors’ harrowing experiences with psychiatrists and other medical personnel; on legislation and litigation; and, especially in *Phoenix’s* case, on the need for self-help groups that could serve as alternatives to psychiatry. Even though—or perhaps precisely because—both editorial collectives maintained an explicit, categorical ban on articles advocating or accepting a “medical model” of mental distress, debates about how to contend with new genres of biogenetic and pharmacological reasoning that were rapidly acquiring commonsensical status in the public domain were rare in both journals, if not non-existent. This meant that the emerging logic of biospecific psychiatry went largely uncontested. The DSM-III’s transformation of psychodynamic terminologies that were usually adjectival in nature (e.g. Alé’s “schizophrenic reaction”) into stable, nominal designations (schizophrenia, agoraphobia, anorexia; see Luhrmann 2001: 227) gave the public a versatile new lexicon for medicalizing troublesome thoughts and feelings, preoccupations and inclinations. It became increasingly possible for someone to be anti-electroshock, anti-forcible detention, anti-Thorazine, anti-Haldol, and anti-Prolixin, anti-four-point-restraints, anti-asylum, anti-solitary confinement, anti-stigma, and pro-patients’ rights without being even slightly anti-psychiatry.

---

51 In the entire publication history of *Phoenix Rising*, the DSM was mentioned in a total of ten articles, all of which (except one) simply stated the manual’s invalidity without analyzing, or even acknowledging, the structural changes introduced into its third edition. The sole exception appeared in a fall 1983 interview between an anti-psychiatry radio host and a science fiction writer: “Delany [the writer]: Someone has just recently come out with an attempt ot [sic] make a more careful diagnostic pattern for ‘mental illness’. / Markman [the host]: The DSM III? / Delany: Yes” (Markman and Delany 1983: 10, *PR*). The radio host then pointed out that, unlike other medical diagnoses, psychiatric diagnoses have no clear biomarkers; the interview then shifted to the topic of literary representations of madness. I could find only one brief mention of the DSM in my set of *Madness Network News* issues: a short announcement in the very last issue (summer 1986) warning of the impending release of the DSM-III-TR.

52 Three of the most common antipsychotic drugs at the time. Their effects on patients’ phenomenological states were notorious and covered extensively in the anti-psychiatric press. As one patient put it, “These drugs do not calm or sedate the nerves. They attack. They attack from so deep inside you, you cannot locate the source of the pain. The drugs turn your nerves in upon yourself... These drugs are designed to render you so totally involved with yourself physically that all you can do is concentrate your entire being on holding yourself together” (quoted in Frank, *MNN* 1981/1982: 28; ellipsis in original). When reading descriptions like these, I was struck at the similarities between the central, orienting metaphors that these patients deployed and those that my own informants did: namely, the spatial representation of “drugs” as foreign agents overwhelming and assailing their bodies and consciousness, as opposed to restoring them to normalcy as is typically portrayed in the mainstream press (see chapter 5).
With the reform of mental health acts throughout North America toward the end of the 1980s, which leveraged the new biospecific logic in support of expanded outpatient treatment, it also became possible for people to identify as psychiatric survivors or consumers without having ever set foot in a mental institution—the traditional target of anti-psychiatry activism. Citing the rise of new pharmaceutical subtypes, politicians additionally began to pass legislation requiring that psychiatric inpatients be discharged only on condition that they stay on their medications after their release (Fabris 2011). Discharged patients would be regularly monitored by community nurses and health workers, and violations would result in rehospitalization. In Ontario, this type of legislation was first proposed in 1989 by Liberal MPP Shirley Collins, and, although former patients decried it as a “leash law” (Browne 1989: 26, PR; Shimrat 1997: 78), it was written into the Ontario Mental Health Act in 2000 (Government of Ontario 2010). In 1993, the Ontario government announced its “intention to close one half of the remaining psychiatric hospital beds by the year 2003,” and to reallocate a portion of the savings to community outpatient treatment initiatives (Everett 1994: 66). To many patients, “Community mental health meant that instead of going to the expense of keeping you within walls… the professionals would just install the walls inside your head” (Shimrat 1997: 59). Ironically, the longstanding anti-psychiatric tactic of publicizing the indignities of asylum life imparted the new mandatory outpatient treatment laws with a kind of commonsense: observers could enthusiastically agree that mental wards should be shut down while still viewing patients as mentally ill.

Finally, despite the fact that reliable biological markers of “mental illnesses” have never been established, new pharmaceutical compounds were marketed in the wake of the DSM-III as “cleaner,” “safer,” “far more effective,” and neurochemically “targeted” in comparison to an older generation of medications (Coleman 2008: 349, 351; see also Rose 2003, 2004; Whitaker 2002). This was a key move, as, up until this time, psychotropic drugs had generally been marketed to doctors as tranquillizers that would alleviate external symptoms rather than as therapeutics that would restore a patient to functional normalcy (Luhrmann 2001: 225-226). By the late 1990s, “it was more common than ever to be told that mental illnesses were chronic conditions that often required a lifetime of cocktail drug therapy” (Coleman 2008: 351). Indeed, as Unhinged members often told me with more than a hint of disgust, they had generally only

---

53 This was the tactic of choice for anti-psychiatry activists well into the late 1980s. In the second last issue of MNN, a writer argued, “If the homeless and other ‘mentally ill’ persons were treated voluntarily in an atmosphere of respect and dignity, many more would seek help” (Zimmerman, MNN 1986: 12). This is surely true, but the extension of therapeutic governmentality throughout civil society in respectful, dignified guises is laden with its own problems (see Rose 2003, 2004).
ever encountered the notion of “self-help” services for “C/S/X clients” in the context of mental health personnel reminding them to “take your meds, take your meds, take your meds.” In chapter 6, I will examine the ways in which the biological resignification of “recovery” erases the experiences of people who recover from “mental illness” outside the purview of biomedicine. For now, what is key is that these new marketing strategies reinforced the notion that psychiatry had undergone a bona fide revolution: it was seemingly, as Robert Spitzer had put it to the New York Times, becoming more of a science.

Beginning in the 1980s, “pharmaceutical companies expanded direct-to-consumer advertising in magazines and newspapers with the [ostensible] intent of empowering consumers who were newly focused on the notion of patient autonomy” (Gellad and Lyles 2007: 475). Since then, an invigorated pharmaceutical industry has set into motion a growing societal acceptance of, and even desire for, chemical prosthetics and elixirs for all of our embodied needs and wants: sexual, dermatological, gastrointestinal, neurological, and otherwise. By employing a language of choice and preference in a marketplace of alternative services, the new ideology of medical consumerism aligned closely with “economic and cultural shifts that entrenched a new commonsense language of freedom centered on the ideas of lifestyle choice and free market principles” (Coleman 2008: 357). It also fortified the neoliberal enjoinder for market democracies to eschew “medical monopolies” that could exploit paying clients (Crossley 2006: 203). Within this framework, consumer choice was not just an ethical imperative, it became the new engine of collective identity, providing a vocabulary and conceptual orientation for a multitude of new proposals, initiatives, and projects emerging from psychiatric ex-patient communities. Grassroots anti-stigma campaigns increasingly accepted bio-pharmaceutical models of “mental illness.” For example, the inaugural editorial of a Washington D.C. patients’ liberation newsletter called Mad Lib (subtitled, “The Voice of the Ultimate Civil Rights Movement”) sought to combat stigma using the following comparison:

Mad Lib is dedicated to two propositions. The first is that abuse of mental patients, whether subtle or overt, is traceable in large part to the stigma that society attaches to mental illness. The second is that the surest cure for stigma is the truth. The more we know about mental illness, the less frightening it becomes… John and Jim both have a bio-chemical imbalance alterable by medication. John’s imbalance is called schizophrenia, Jim’s diabetes. John is stigmatized, Jim is not (“Nothing to Lose but our Stigma” 1987: 1, Mad Lib; emphasis mine).

The editorial leaves the implicit question (i.e. why this is so) unanswered, presumably so that the reader can reflect on the injustice of the double standard. The comparison is problematic, however, in its insistence that madness is biochemical sickness. As Shimrat (1997: 26) has observed about anti-stigma campaigns, “these educational efforts have been based on the notion...
that crazy people are sick and that it’s okay to be sick.” Indeed, the fragmentation of anti-psychiatry during the 1980s was exacerbated by an intimate linkage between this notion and what Perring (2009: 5) has called “benevolence stigma,” whereby a psychiatric diagnosis is accepted as a durable biological deficiency that bars a person from a “normal” life and entitles them to paternalistic treatment. The notion that it’s okay to be sick also began to re-legitimize forcible detention and involuntary treatment in the eyes of some constituencies in the patients’ rights movement. The October 1986 issue of Phoenix Rising sounded the alarm on the emergence of a new patients’ rights group in the United States called the National Mental Health Consumers’ Association (NMHCA) that seemingly betrayed a central principle of the liberation movement. Founded in the wake of the 13th Annual Conference on Human Rights and Psychiatric Oppression, the NMHCA conceded that “forced treatment” is sometimes acceptable, even as its mandate urged “a positive portrayal of, and understanding and sensitivity toward, current and former mental health clients” (McKinnon 1986: 7, 10, PR). Not by coincidence, this announcement also took place at the final Conference on Human Rights and Psychiatric Oppression, which was torn apart by infighting that very year (see section 3.3.2 below).

In 1986, psychiatric “consumer” groups lobbied the U.S. Congress to introduce advocacy councils in all fifty states to safeguard the rights of mental patients: Congress complied, and, using a client/service-provider logic in the new Protection and Advocacy Act for Individuals with Mental Illnesses (PAIMI) Act, made it a requirement that “at least 60 percent of the membership of the governing advocacy councils be ex-psychiatric patients or their families,” since families were ostensibly also being served (Rissmiller and Rissmiller 2006: 865, emphasis mine; see also Bluebird 2004). As Gracie put it,

It came full circle. Such a betrayal. When things were fringe, it was always understood family was—it is so often the case it’s moms and dads who put kids into these torture chambers, they’re not being goody goody [for example] going veggie (vegetarian) or growing their hair. They (parents and family members) didn’t speak for us, they spoke for us. A lot of times, it’s families who put you in hell in the first place, uh, in terms of, like, sexual abuse and, and whatnot, and then dad tells the shrink, ‘Oh don’t listen to anything she says. She’s nuts.’ [That’s] Why you go mad. … Madness [Network News] always got that, always. Nothing about us without us! (a popular slogan in the Mad movement)

Gracie’s depiction of psychiatric consumers’ participation in the passage of the PAIMI Act raises important questions about our society’s treatment of parents’ consent as a proxy for their children’s wishes. As the Philadelphia Association for the Liberation of Mental Patients pointed out in 1979, the notion that parents should always be entitled to determine the “best interests” of their children ignores the fact that many “children are locked up in mental institutions because they have resisted parental oppression—running away, skipping school, physically defending
themselves against beatings… mental institutions serve as the ultimate control mechanism to keep their children in line” (quoted in Dain 1989: 24). On the other hand, as my conversations with Acceptance members made poignantly clear, it is often the case that parents are the ones who feel betrayed by psychiatric interventions, and their motives for entrusting psychiatrists with their children are typically love and desperate concern, not disciplinary or punitive impulses (see chapter 6). Because people can have different understandings of normalcy, and because of the way in which psychiatrized thinking permeates our society, it is unsurprising that “what is experienced by the individual as a small personal difficulty, which will pass without any outside intervention, [may be] seen by friends or relatives as mental disorder in need of treatment” (Prior 1999: 77). As we will see in chapter 6, the inadequacies of the “consumer/service” metaphoric dyad are no less stark to those who are not psychiatrized and who nonetheless find themselves subjected to constant moral and intellectual scrutiny by their family’s “service providers.”

3.3.2 A Penny For Your Thoughts: Professionalization and the Co-optation Debates

By the mid-1980s, anti-psychiatry groups that adamantly rejected state sponsorship and maintained an abolitionist stance on psychiatry, including both Madness Network News and Phoenix Rising, found themselves in dire financial straits. MNN began to encounter serious budgetary problems in the year leading up to its Winter 1983/1984 issue, and its editors implored readers and subscribers to send in donations. In 1986, MNN published its final issue and its editorial collective disbanded. According to Chamberlin (1990: 334), “[i]ts all-volunteer staff became exhausted by the effort of putting out the newspaper with no funds,” and the paper’s financial situation surely played a role in its demise. However, the primary literature from this period reveals a more complex story and entreats a closer reconstruction of the events leading up to the summer of 1986.

In early 1985, an essay entitled “Co-optation and Democracy” appeared in MNN (see Figure 3.15 in Appendix II). It was authored by long-time MNN contributor Lenny Lapon, who was known for his multi-page exposés of eugenic programs and his denunciations of psychiatry’s serviceability to capitalism. The piece began with the line, “My stomach is in knots. I feel a tremendous amount of sorrow and anger and alienation,” and continued by condemning a widespread, dangerous and increasing trend of co-optation in the psychiatric inmates/“mental patients” liberation movement. The trend has always been there. I, for one, am feeling more and more uncomfortable with and alienated from its present form and manifestations. The independence of our movement is being threatened, as more of the so-called movement projects—teleconferences, organizing of ex-inmates, conferences, “self-help” groups and the like are being funded by our enemies at NIMH [National Institute of Mental Health]. … This clever carrot-and-stick approach is nothing new. We’ve always been thrown a few crumbs along with our Thorazine. Money means control—no two ways about it. … There is much
blood on their money, on the salaries ex-inmates accept, on the money given to us for travel and other expenses. And, of course, as ultimate control, they can always cut off funding at any time.

I strongly believe that they love to fund “safer” activities, such as those labeled “self-help” and “consumers”-this and “patients”-that. They are pushing many of our numbers to concentrate on these issues on their terms. I hate those terms and what they stand for. I am not a self-helping consumer of “mental health services.” I am a liberation fighter—struggling against psychiatric oppression, tyranny, and murder. We used to often use the term “mutual support” to describe the way in which we tried to give each other emotional support. We’ve lost a lot more than the term, when we call ourselves self helpers, consumers, and patients. It is not just semantics.

The counterpart of this co-optation is the issue of democracy within our movement. We have a tremendous amount of work to do in this area. I am so tired of un-elected people, and even worse, people selected by NIMH, the APA [American Psychiatric Association], and local psychiatric and “mental health” associations and departments, professing to represent the psychiatric inmates liberation movement. It’s about time we addressed the reasons for the selection of certain “representatives.” I believe they are often chosen because they are willing to talk about the “safer” issues, to temper their words, to concentrate on “self-help,” stigma, token alternatives, and the like. They can be counted on to minimize and, in some cases, ignore the other issues of our struggle—the forced drugging and its consequences, electroshock, killings and social control committed by NIMH, the APA and their local agents.

… I would like to inform all of you who are participating in the teleconference, who are paid by NIMH and other branches of the “mental health” system and/or who otherwise appear in public as self-proclaimed representatives of the psychiatric inmates liberation movement, that you certainly don’t represent me. I’m sure there are many others in the movement who feel similarly. …You represent yourselves, your teleconferences and at times your local organizations.

…I hope that one or two people do not take these criticisms personally, but that we all do—we must all take it personally, for the personal is political and I do hope we’re using a political model to fight our political oppressors (Lapon 1985: 6, MNN; emphasis mine).

Some readers concurred with Lapon, and MNN published some of their gratified replies in the next issue. “In the final analysis,” one woman wrote in, “psychiatric oppression will be eliminated only if society itself is transformed—radically and thoroughly” (Clay 1985: 20, MNN). And as another pointed out,

I do support those working for reform. Working within the system is vital for people currently entrapped, with no options. Changes are needed for those suffering right now, today. But reform does absolutely nothing in the long run. The psychiatric system just cannot be separated from the capitalist/imperialist system. … Reform creates surface change—individual solutions to individual problems, with individuals who do benefit. (Which is one of the deadly roles psychiatry fulfills, to adjust individuals to their oppression.) … Reform itself is co-optation, if that is where people stop (Doell 1985: 20, MNN; emphasis mine).

However, the underlying point of contention was foreshadowed in the 1978 to 1979 Sally Zinman/John Latz exchange (section 3.2). Readers who saw no problem with “the” movement’s focus on enhancing psychiatric patients’ living conditions and access to rights, information, and rehabilitative services also saw no problem in partnering with branches of the mental healthcare infrastructure that were, after all, best positioned to facilitate these enhancements. Judi Chamberlin, in particular, took serious issue with Lapon’s j’accuse. In the summer of 1985, she countered, “If we are to take money only from sources we find politically ‘correct,’ we are going to remain poor, and poorly organized, for a long time to come,” and she pointed out that Lapon’s despair was premature, since the NIMH and APA had not imposed any ideological or tactical
prohibitions on the groups they funded (Chamberlin 1985: 18, MNN). Another reader, Paul Dorfner, contested Lapon’s argument in a somewhat different way—he argued that the salary he drew from the NIMH through its Community Support Program represented his own personal victory over the mental health system. “I’m sure,” he asserted, “that they resent the fact that I’ll be a successful closure. …I guess this is where you and I differ. I have always and I mean always seen this as the liberation struggle—to succeed against them” (Dorfner 1985: 19, MNN; underlining in original). In a sense, Dorfner too was deploying the classical feminist reminder that “the personal is political.”

In February 1985, Phoenix Rising ran an article on the 12th Annual Conference on Human Rights and Psychiatric Oppression, which had taken place in June 1984. In it, the authors observed without elaboration that “[t]he issue of professionalization is a touchy one within the Mad Movement” (Boldt and Nihera 1985: 48, PR). In late 1985, a brief item appeared in MNN announcing that the original sponsors of the 13th Annual Conference on Human Rights and Psychiatric Oppression, a Quebecois group called Auto-Psy, could no longer host the Conference due to member burnout (“Quebec Cancels” 1985: 6, MNN). The 13th Conference was eventually held at the University of Vermont in August 1985. Phoenix Rising’s coverage of the 13th Conference in the actual year it occurred contained no hint of trouble: the event was described as having taken place in “a beautiful, and peaceful setting” and as having been “organized by the Vermont Liberation Organization (VLO), an ex-inmate group which did an outstanding job and made us all feel welcome” (Geisler and Weitz 1985: 40, PR). However, a more ominous note was sounded a year later in an October 1986 Phoenix article entitled, “The Movement: Issues, Problems and Hope in California,” which presented a quite different picture of events in Vermont:

Some people fear that the Psychiatric Inmates’ Liberation/Antipsychiatric Movement is about to collapse. The issue of factionalism, or splits in the movement, has caused a great deal of anxiety and bitterness, particularly since the 13th Annual International Conference for Human Rights and Against Psychiatric Oppression, held in Burlington, Vermont in August 1985.

… The issue that poses the most significant threat to the unity and future of the movement is government funding to ex-inmate self-help/advocacy groups. Many ex-inmate activists fear that such funding will have disastrous effects on groups that accept it. They fear that groups taking government or “mental health” funding will lose their autonomy, and that they will be co-opted by and absorbed into the “mental health” system. These fears are not unrealistic or overstated. This has happened to other radical self-help organizations created as alternatives to the system.

… These factions reflect major ideological and political conflicts that have taken a serious emotional toll on those who previously derived strength from their commitment to a common cause. Many movement people who have been friends [have] become alienated from each other after splitting into different factions. This is now little mutual trust. According to Leonard Frank (shock survivor and anti-
shock activist, author, and highly respected movement leader), this alienation has become so intense that “we’re no longer looking at each other as human beings who share the same victimization… We seem to have subordinated that to our political roles, and as a result people are not relating to each other as friends, as brothers and sisters.” In fact, barely-disguised insults have become part of many political discussions. The label “reformer” is used to dismiss certain people who have been fighting in the movement since its beginning in the 1970s. And people who are committed to a radical-abolitionist position are sometimes labeled “blinded purists,” and even “reactionaries.”

The crisis situation also threatens the political integrity and credibility of the movement. One can imagine the satisfaction that a shock doctor or NIMH bureaucrat must feel about these developments. As Leonard Frank says, “It’s a perfect thing from the establishment point of view to have so much of our energies drained off fighting against each other” (McKinnon 1986: 6-7, PR; third ellipsis in original).

The fallout from the 13th Conference proved insurmountable, and no additional Conferences on Human Rights and Psychiatric Oppression were ever held. In June of 1985, a new annual conference (“Alternatives”) was launched, which was indeed funded by the NIMH. At the inaugural Alternatives conference in Baltimore, Maryland, the term “consumer” was officially selected as a pan-movement identity category that underscored psychiatric patients’ right to participate in decisions relating to their treatment (Bluebird 2004: 46). While many conferees acknowledged that the “consumer” metaphor was flawed, they decided that the philosophical underpinnings of a client/service model would enhance their negotiating power with medical personnel (Bluebird 2004; see also Crossley 2006: 67). One informant critiqued this reasoning in the following way, via email: “They kept using this bourgie newspeak. ‘Consumers and [service] providers and all other stakeholders.’ … Yeah, guy, they have a stake in consuming us so they and their ‘provider’ buddies can live in mansions. Don’t know about you, but I have a stake in not getting consumed.” Sue Doell, a long-time MNN reader similarly pointed out, “My dictionary says to ‘consume’ means to eat, drink, to use up, to waste, to destroy. The mental health professionals are the ‘consumers’” (Doell 1985a: 20, MNN). In a December 1985 letter to Phoenix Rising, Doell excoriated the magazine’s editorial collective for publishing an article on deinstitutionalization in Italy under the headline, “Italy Humanizes Psychiatric System.” In a scathing critique of reformist frameworks, Doell stated,

I was so excited to learn that Italy was closing their psychiatric institutions that I cried. But since that first tearful reading, I have re-read your story and asked questions of people who have been involved in that process. The whole thing is nothing more than the same economic transfer of psychiatric power that we experienced in the U.S.

---

Leonard Frank survived fifty insulin comas and over thirty electroshocks during seven months of institutionalization for “paranoid schizophrenia,” and was a prolific contributor to Madness Network News from 1972 through the early 1980s. Frank also co-founded San Francisco’s Network Against Psychiatric Assault (NAPA) and spearheaded the nearly successful 1982 campaign to have ECT outlawed in Berkeley, California (Phoenix Rising Editorial Collective 1982: 31, PR; Frank 2006: 154). When psychiatric inmates’ groups began soliciting NIMH funding and participating in policymaking in the mid-1980s, Frank took an extended hiatus from direct activism and transferred his energies to personal writing/editing projects.
You glorify the creation of a more insidious psychiatric state. Neighbourhood “mental health centers” are community-based tools of social control. In the U.S., these neo-institutions are notorious for their massive drugging practices. There are no “problems” (as you say) with these psychiatric reforms. It’s the very nature of reform. … “Italy has become a model of mental health reform”??????? No, not at all. But Phoenix Rising has become a model of a very fine journal in the clutches of co-optation (Doell 1985b: 3-4, PR; paragraphing in original; emphases mine).

Doell’s argument was essentially that “the very nature of reform” was to introduce decentralized forms of medical surveillance that would be voluntarily used by psychiatric consumers and, therefore, harder for anti-psychiatric activists to oppose. In an echo of Raymond Williams’s famous observation that “much incorporation looks like recognition, acknowledgement, and thus a form of acceptance” (1977: 125, quoted in McElhinny 2006: 142; emphasis in original), Doell contended that deinstitutionalization—the closure of psychiatric wards and devolution of healthcare services to community agencies—represented not a landmark victory for opponents of psychiatry, but a major setback, for psychiatric coercion was no longer contained behind institutional walls. Likeminded activists mounted a resistance by creating their own pan-movement identity category (“survivor”) and founding the National Association of Psychiatric Survivors in December 1985, “specifically to counter the trend toward reformist ‘consumerism’” (Chamberlin 1990: 333; Havel 1992: 33). Although this organization no longer exists, the term “survivor” persists in mental health discourse to this day, sitting uneasily alongside “consumer,” “ex-patient,” “Mad,” and sundry other identity categories, a point to which I will return shortly.

In 1986, the Phoenix Rising editors asserted, “If the crisis gets much worse, we may no longer have an antipsychiatry movement… In overcoming the crisis, we must reach down deep within ourselves and touch our roots. These roots are embodied in our Declaration of Principles” (Phoenix Rising Editorial Collective 1986: 2, PR). As we have seen, the 1982 Declaration of Principles affirmed a strong commitment to the development of alternative services, advocacy/rights groups, and crisis centres under the control of “users.” And, in fact, the “reformers” mentioned in the above excerpt were past or present “users” of mental health services who saw nothing unethical about being paid by NIMH or the Canadian Mental Health Association (CMHA) to do what they had always done: coordinate and facilitate patients’ self-help groups, and serve as consultants for hospitals and other institutions. One prominent activist pledged, “I’m not going to be co-opted. I’m not going to forget what psychiatry did to me” (Jay Mahler, quoted in McKinnon 1986: 10, PR). Many “reformers,” like Chamberlin, had

---

55 Documentary evidence of its activities drops off sharply in the early to mid-1990s. However, no clear date of closure is specified in the available primary or secondary literature. It is possible that, as with many defunct political groups, membership and participation simply trickled away over time. Recent historical accounts acknowledge this group solely for its popularization of the “psychiatric survivor” concept and its ideological rivalry with the National Mental Health Consumers’ Association (e.g. Reaume 2002, Weiner 2011).
contributed to the legal victories of the 1970s at considerable personal expense and saw no
shame in seeking to improve the system from within while drawing a salary. During a similar
debate in the United Kingdom, one of Crossley’s informants deployed a slightly different logic,
asserting that being paid for one’s advocacy ensured that one’s input would be respected: “Real
influence is getting paid to do consultancies and getting paid big, getting paid proper money,
good money, same as any other consultant in the country would get. Because if somebody pays
£28,000 for a piece of work they ain’t going to ignore it” (quoted in Crossley 2006: 203).

There is some merit to this argument: a major goal of social justice activism is to
ameliorate suffering in the here and now, and this can require activists to first clinch positions of
material influence. It is also true that, as MacDaniel pointed out during a different controversy
that arose during my fieldwork, “Just cause you used to suffer doesn’t mean you have to suffer—
like, finally being able to eat steak isn’t a crime.” However, it is also arguable that “survivors
acquire a stake in the system this way, which will lessen their readiness to challenge it”
(Crossley 2004: 177). MNN readers who were less sanguine about NIMH’s growing role in the
psychiatric ex-patient/inmate/survivor community continued to reply to Lapon’s essay well into
1986—the journal’s terminal year—and some deployed precisely this logic.56 One reader, Nancy
Foley, recounted a similar debate in the “battered women’s movement,” where radical feminist
groups that accepted government funding eventually became part of the state surveillance
apparatus by agreeing to monitor residents’ activities on behalf of the police, child welfare, and
mental health agencies (MNN 1986: 11). Foley concluded,

One writer [Chamberlin] suggested that we accept the money and worry about correcting co-optation of our
movement if and when it occurs. But it may be too late; the economic structure of our organizations
influences the attitudes that we have. While the feminists who originally accepted state funding realized
they were making compromises because they had to, and the shelter was not as they would ideally like it to be,
most of the women working there now accept the structure as it is. The source of funding has affected
even the type of people who make up the organization; shelters now hire professional women with
backgrounds in social work or counseling. I say that whoever pays our bills inevitably owns us. It is
possible to reverse the trend toward co-optation, but only after many people have been hurt. It would
require a great deal of consciousness raising—the movement would have to be reborn (Foley, MNN 1986:
11; emphasis mine).

Gracie, who never considered herself a “true” activist but had participated “off and on” in a
number of small “self-help” groups in the 1980s, similarly positioned “co-optation” as an
inevitable consequence of accepting the parameters of the status quo: “NIMH’s [which she
pronounced “nimmy’s”] a fucking drug mill—for chrissake—I mean, what, you wanna make the

56 Lapon helped to keep the debate alive by undertaking a hunger strike from 13 December 1985 to 10 February
1986 “to put forward a strong anti-psychiatry position for those who are hedging on taking a stand against co-
optation.” He stressed, “I hope those who have left our movement and are now on the NIMH payroll will reconsider
Thorazine cherry-flavoured? … Don’t wanna wake up in Hell? Don’t sleep with the fucking devil.”

It is important to note, however, that some readers who heartily agreed with Lapon’s warnings about co-optation did not look kindly on his reputation for identifying resistance against psychiatry with resistance against capitalism. One reader, Anne Darcas, who strongly reproached NIMH/APA-funded ex-inmate/ex-patient groups for “compromising their integrity,” also indicted “the long-standing opinion of many mental-patients lib activists that a main cause of psychiatry is capitalism” (Darcas 1986: 9, MNN). She continued,

That is you peoples’ analysis. It isn’t mine. … let’s don’t make people feel that in order to join us in our struggle against shock ‘treatments’, etc. they have to be against capitalism or want to work for the entire downfall of the US government. The anti-psychiatric umbrella is one under which people of many different economic and political persuasions may gather (Darcas 1986: 9, MNN).

While little can be inferred about this reader’s background on the basis of this letter, the tactical rationale that she advocates—toning down political analyses in order to make anti-psychiatry more welcoming to a broad range of constituencies—brings to mind Dain’s (1989: 21) observation that middle-class anti-psychiatry activists were far less likely than their working-class peers to have anti-capitalist politics, and that, despite the early writers’ efforts to link psychiatrization with capitalist inequalities, most anti-psychiatry groups in the mid- to late 1980s had virtually “no class outlook.” The tactic of curtailing socio-political critiques so that all may gather beneath “the anti-psychiatric umbrella” also arguably leads to precisely the types of decontextualized, bio-centric understandings of “mental illness” that make partnering with mental healthcare providers like the NIMH, the APA, and the CMHA seem like natural objectives. Because activists who possessed certain skill sets—and the cultural capital implicit in them—were typically better situated to serve as representatives of “the movement,” anti-psychiatry activists with college degrees and/or middle-class social graces tended to advance more quickly within the quasi-professionalized sphere of mental health advocacy. In contrast, those who were deemed too rude or angry (and, as one informant suggested, “too scruffy”) to cooperate productively with mainstream organizations were sidelined, as were the concerns that were unique to their lives (Shimrat 1997).

In early 1986, dissent began to brew within the Madness Network News’ editorial collective itself. Seeing themselves as the longstanding radical voice of the movement, a majority of editors felt a unique “responsibility to support and to keep our readers informed of

57 Although NIMH is an American organization, Canadian activists followed events in the U.S. closely, and many subscribed to and wrote for the Madness Network News. The NIMH has never had an exact Canadian counterpart; however, Irit Shimrat (1997) identifies the Canadian Mental Health Association as a comparably repugnant source of funding, which Phoenix Rising sedulously avoided.
the movement to abolish psychiatry” (MNN Collective 1986b: 18; emphasis in original). To this end, MNN had always upheld an unequivocal ban on printing articles that espoused a “medical model of ‘mental illness’” (MNN Collective 1986a: 2). During the winter of 1985 to 1986, this policy acquired a controversial edge due to the previous year’s events: specifically, MNN began to receive submissions announcing the emergence of national patients’ groups such as the National Alliance of Mental Patients (NAMP) that accepted the “medical model” and was open to receiving state funding (1986b). MNN declined to print many of these submissions, reasoning that “We feel no need to give space to organizations which support and work within the psychiatric system. We feel confident that people who want it will have no trouble getting information from them directly” (1986b: 18). Moreover, the editors had recently dispatched a questionnaire to all “movement groups” that had traditionally been listed in the MNN’s anti-psychiatry directory, and were “horrified to discover that some groups are not opposed to electroshock,” and, even worse, several were not even “opposed to forced psychiatric intervention” (1986c: 2). In an effort to redress what they saw as a serious withering of their movement, the MNN Collective decided to organize a new conference to be held in May 1986, where attendance would be limited to ex-patients/activists who received no “mental health” funds, salaries, grants, or honoraria whatsoever; and who “unequivocally” agreed with the 1982 Declaration of Principles (MNN Collective 1986d: 3). One long-time MNN editor, Morgan Firestar, was outraged by this move. In a sidebar titled “A Dissenting Opinion,” Firestar asserted,

I don’t think that MNN… has the right to decide which groups and/or individuals are ‘legitimate’ members of the anti-psychiatry movement, and I object to what I see as the beginnings of such judgments… Who has the right to decide that ex-inmates who have been fighting psychiatry for years are now ‘enemy’ or ‘pro-psychiatry’ because of their choice of tactics? (Firestar 1986: 3, MNN; underlining in original indicates the journal’s title rather than emphatic stress)

This brings us to MNN’s collapse in the summer of 1986. MNN published a final issue, which was much slimmer than previous issues, and which focused chiefly on the recent founding of the Network to Abolish Psychiatry, whose mandate was “to ensure the survival of an autonomous anti-psychiatry movement” (Network to Abolish Psychiatry 1986: 8, MNN; see Figure 3.16 in Appendix II). Although readers were not privy to the internal debates that had led to this juncture, the one remaining editor (Anne Boldt, who also reported for Phoenix Rising) informed readers that the editorial collective had dissolved. She had completed the issue on her own, and decided to include a draft of a statement that the MNN Collective had put together prior to their dissolution, which she stressed was not officially approved. The statement read,

The current Madness Network News Collective is dissolving after this issue. As we go to the printer, the future of the paper is unknown. If Madness is to continue, there is an urgent need for new collective
members and volunteers. We especially call on people with strong ANTI-PSYCHIATRY politics to join the paper. There is a definite possibility that MNN could become a voice of the recently expanded “mental health client/consumer” reform movement. We feel that this would be an insult to the entire history of Madness Network News. We implore MNN readers not to let this happen. And… if people do not come forward very soon the office will be closing.

Madness is also in dire shape financially. Regardless of the future of the paper, donations are crucial at this time. This issue of the paper must be paid for, along with the office rent in the coming months. Many donations, orders, and renewals will be needed if the paper is to continue publishing. This also may be a good time (and last chance???) to order MNN back issues, or the MNN Reader, etc.

Before we leave, we’d like to thank all of you who have been so supportive during the past several issues. This has been a very strenuous time for MNN and the anti-psychiatry movement. We, also, feel the strain. The effort by NIMH/CSP/APA to co-opt our movement with funding has been very successful.

First Ending

Very few anti-psychiatry projects remain. But one thing is certain, no matter how unorganized the movement may currently appear the public—and underground—resistance to psychiatric assault and psychiatric oppression will continue to grow. Psychiatry will one day be abolished.

Second Ending

A lack of real communication and trust in recent years among people has been another major cause of this success and continues to jeopardize [sic] what is left of our movement. In addition overwhelming personal problems makes it impossible for some of us to remain involved. Very few anti-psychiatry projects remain. Those that do tend to be isolated. It remains to be seen whether or not a visible, organized anti-psychiatry movement will continue to exist at this time (Madness Network News Collective 1986e: 2; underlining, italics, formatting and ellipsis in original).

Finally, internal rifts amid financial hardship also hastened the demise of Phoenix Rising. Starting in 1987, Phoenix began to run full-page exhortations under headlines like, “Are you rich? Do you know someone who is?”, accompanied by the explanation that “we never know until the last minute whether we have money to put out a given issue or not … help us out with a generous donation” (Phoenix Rising Editorial Collective 1987: inside front cover, PR). In its second last issue, Phoenix enigmatically announced it was suspending publication for twelve months in search of “a permanent address, a steady source of funding, and more people to work on the magazine” (Phoenix Rising Editorial Collective 1989: 2, PR). The reason was not disclosed to readers until Phoenix’s final issue a year later: the Ontario patients’ self-help association, On Our Own, had evicted Phoenix from their jointly occupied office in the summer of 1988, closed their jointly operated used goods store—Phoenix’s primary source of funds—and passed a motion dissociating itself from the magazine, due largely to Phoenix’s refusal to moderate its opposition to psychiatric medication (Weitz 1990: 12-13, PR). On Our Own (whose executive no longer unconditionally opposed involuntary medication) and Phoenix (whose editorial collective steadfastly did) were no longer on the same ideological wavelength; each viewed the other as in violation of the principle of choice. Whereas On Our Own argued that patients had a right to freely choose institutionalization and whatever it entailed in pursuit of
health, *Phoenix* argued that freedom of choice was impossible within the existing system because patients were denied access to impartial information about the adverse effects of different treatments. Alé, who by this time was living in Toronto, characterized *Phoenix’s* stance on this issue as “really, well, really ahead of its time—it might not have caught so much heat today,” alluding to a litany of recent public disclosures about the health risks of widely prescribed pharmaceuticals (e.g. Zyprexa and its link to diabetes, see chapter 4).

*Phoenix* folded in July 1990, never to rise again. Don Weitz announced the magazine’s closure in an interview with the *Toronto Star*, stating, “We can’t go from hand to mouth anymore,” but also affirming, “We’ll take nothing from the Ontario Ministry of Health. We don’t want to be co-opted” (Morris 1990: C3). In a final editorial entitled “Farewell,” *Phoenix’s* editors expressed pride in their decade of “maintaining our independence and integrity by refusing to be co-opted by the government and the ‘mental health’ system (we have never either solicited or received ‘mental health’ funding)” (*Phoenix Rising* Editorial Collective 1990: inside front cover, PR; see Figure 3.17 in Appendix II). Indeed, in some readers’ eyes, *Phoenix’s* independence was precisely what set it apart from other anti-psychiatry groups, even if their respective politics were similar. An informant (female, aged 59) who had occasionally purchased the magazine at the Toronto Women’s Bookstore stressed that she tended to find the editors’ tactical choices problematic. In particular, she found *Phoenix’s* frequent focus on “atrocities” dismaying (“As soon as you start up about Nazi psychiatrists and Ewen Cameron, you lose. People tune out—they go, ‘Yeah, but those were freak cases—doesn’t happen anymore”). Nonetheless, she was emphatic that *Phoenix* was one of the few radical political journals that “really got it” when it came to eschewing “mental health money,” and she acknowledged feeling devastated by *Phoenix’s* farewell message. “I cried,” she said. “I remember thinking, ‘Who’s left? Who is there who still gets this stuff? Is this it?’”

Malcolm, who had ceased to be politically active by the early 1980s due to burnout, had never seen the final issues of either *Madness Network News* or *Phoenix Rising*. When I gained access to copies, I asked him if he would like to look at them. At first, he replied eagerly in the affirmative. However, by the next Folie à Deux meeting, he had changed his mind. “I don’t need to,” he said. “Can’t change anything anyway.”

Satisfied that the matter was closed, he then turned to Cassidy and began asking her about the merits of different vitamins.

---

58 Donald Ewen Cameron (1901-1967) was a Canadian psychiatrist who tried to develop a brainwashing technique while on the CIA payroll by experimenting on his patients (Collins 1988).
4. When Counterarguments Collide

It must be emphasized that the above narrative is unavoidably incomplete. The number and diversity of anti-psychiatric groups and initiatives that have come into and out of existence since the 1960s is immense, and I have touched on only some of them. This is due not only to omissions in the historical record and people’s inevitably selective memories, but to the fact that written accounts of social unrest rarely document the dissent that ordinary people exhibit in the course of their daily lives and therefore tend to paint a picture of political struggle as something that is evanescent rather than omnipresent. In chapter 7, I will discuss how new events in the 1990s and 2000s facilitated a resurgence in what is sometimes called “mad politics,” primarily in the form of the Mad Pride movement, which borrows certain discourses from the LGBTQ community to reclaim “madness” as a source of collective identity, albeit not without incurring controversies that recapitulate the ones discussed in this chapter (see also Perring 2009). The increased accessibility of the internet over the past decade has led to the creation of many websites and online forums broadly oriented around anti-psychiatric themes, and has also facilitated networking amongst activists, most notably through the human rights NGO MindFreedom International, whose mandate is “to win human rights and alternatives for people labeled with psychiatric disabilities” (MindFreedom International N.d.a: para. 1).

Many participants in the above groups employ the “C/S/X” term in an effort to assert the fundamental unity of the consumer/survivor/ex-patient community (Morrison 2005). However, for reasons I have alluded to in this chapter, the acronym serves also to conceal serious and sometimes irreconcilable conflicts between those who, often for reasons beyond their control, are forced to bear this label. As we have seen, the deployment of a “client/service” rhetoric in psychiatry gained traction during the 1980s due to a confluence of ideological, economic, biomedical and pharmacological developments, a fact that was not lost on observers of the day. In the inaugural newsletter of the Ontario Psychiatric Survivors’ Alliance (OPSA), which was founded partly to counterbalance On Our Own’s increasingly consumerist leanings (Phoenix Rising Editorial Collective 1990c: 30, PR), one writer delineated the boundaries of the organization by declaring

A consumer gives in to advertising, to pressure, to the wishes of the (service) providers. A survivor has fought, endured and triumphed, like the survivor of Auschwitz (Hurst 1990: 7).

The swift rise of the “psychiatric survivor” framework during the early 1990s may indeed have been facilitated by its semantic association with resilience, courage, and cunning, its juridical
association with eyewitness testimony and firsthand knowledge of criminal violence, and the validation of survivorship terminologies in other movements (e.g. abuse survivor, cancer survivor). As Crossley (2006: 169) has pointed out, the term survivor also “breaks the direct link to illness, challenging psychiatric categorization, and allows for the diverse range of adverse situations that ‘survivors’ have survived,” including life experiences outside the psychiatric system. However, due in part to new outpatient treatment paradigms, “survivor” has always been a blurrier category than “consumer.” For example, when people with only tangential experiences with psychiatry began to get involved in “survivor” groups, some former inpatients reacted with outrage. Sheila, a Folie à Deux regular who had taken antidepressants for a few months in her twenties and was briefly involved with a survivor advocacy group in the early 1990s, observed:

They were quite firm. ‘You will not get a say on this—no debate—cause, you know, you weren’t a mental patient.’ Which I thought, well, hmm, that’s funny. My whole family sees me as one.

To others, survivor seemed hyperbolic. Lanny Beckman, who founded the Vancouver Mental Patients Association in 1970, argued that

the word ‘survivor’ in the term ‘psychiatric survivor’ is misused. A survivor, literally, is someone who really faced death and escaped. And most psychiatric patients were not facing death” (quoted in Shimrat 1997: 55).

The terminology debates are further complicated by the fact that mental health professionals have begun to issue their own definitions of “psychiatric survivor,” asserting that what is being “survived” is not psychiatry but psychiatric illness (e.g. Torrey 2006). Despite psychiatric survivors’ attempts to police uses of the term, these redefinitions have had an effect. Helen, an Acceptance regular, routinely described her husband as a “psychiatric survivor” in spite of the fact that he had never so much as seen a psychiatrist; after all, as she pointed out, he was surviving an experience that had a psychiatric name (depression). Ivy, an Unhinged regular, first learned of the term “psychiatric survivor” in a medical handbook that defined it as anyone struggling with psychiatric distress, and this was the definition that she applied to herself. She, too, had never seen an actual psychiatrist, a fact that made her a target of private resentment among some Unhinged members. Nonetheless, her “symptoms” were arguably just as pronounced as those of other members who, by common agreement, had earned the right to use the term—in one case, by having spent ten minutes in the presence of a mental healthcare worker, and, in another, by having consumed a single Ritalin tablet. Ryan, who was vocally contemptuous of Ivy’s affluent family background, was especially critical of her refusal to
relinquish the “survivor” identity. The many political and epistemological dilemmas that this engendered will be explored in chapter 7.

Whereas “survivor” has become an increasingly blurry category due to the widespread normalization of psychiatric vocabularies and medications since the 1980s, “consumer” has retained a fair amount of stability for institutional reasons. In particular, the current notion that tight correlations exist between specific DSM diagnoses and specific pharmacological classes has given rise to consumer literacy campaigns that encourage people to develop “the ability to recognise specific disorders” and “attitudes that promote recognition and appropriate help-seeking” so that they may knowledgeably select from available medical services (Jorm et al. 1997: 182; see also Haslam 2003, Jorm 2000). Because psychiatric consumers are now said to exercise informed consent and to select from a range of outpatient treatment programs, today’s anti-psychiatry activists “are easily discredited as fanatical” for their perceived unwillingness to accept the field’s progress (Coleman 2008: 358). The narrative of “progress” within psychiatry is of course problematic for many reasons, not the least of which that it delegitimizes the experiences of 21st century inpatients (some of whom we will meet in chapters 5 and 6) whose disturbing ordeals in psychiatric facilities often mirror the stories that once filled the pages of MNN and Phoenix. Moreover, although there is now a widespread consensus that we as a society must combat the stigma of what is called “mental illness,” modern anti-stigma campaigns tend to be grounded in the logic that, to use Irit Shimrat’s phrase, “it’s okay to be sick.” Not only does this “progressive” notion obscure the structural forces and marketized norms that are responsible for much of the anguish that people endure today, it is alienating to individuals who do not see themselves as “sick” and who are nonetheless told that they are obliged to get well. This obligation has recently acquired new urgency due to a plethora of governmental reports and news reports that essentially blame the “mentally ill” for economic stagnation (see chapter 4).

This returns us to the marketization of “mental health” through the consumer/service-provider metaphor, and its unintended consequences. I first want to stress that the activists of the 1970s and 1980s—whatever banner they mobilized under—achieved important legal and juridical victories that have concretely improved the civil status, bargaining power, and living conditions of psychiatric inpatients and ex-patients. As MNN contributor Sue Doell (1985: 20, MNN) pointed out in reply to Lenny Lapon, “Working within the system is vital for people currently entrapped... Changes are needed for those suffering right now, today.” Many such changes have indeed been won. Nonetheless the shift in anti-psychiatry discourse from liberation to involvement during the 1980s not only restored psychiatrists’ claim to expertise over patients’
bodies and brains, it subtly conceded that patients might not always know what is best for themselves after all. Given that receiving a psychiatric diagnosis can already cast doubt on whether one is able to appreciate the consequences of one’s decisions (“legal capacity”), psychiatric “consumers” have often found their wishes overridden, trivialized, or ignored by clinicians and family members. Although it is now commonplace for psychiatric facilities to publish “Bills of Client Rights” that affirm values like the right to identify preferences and to have those preferences considered, these bills invariably include a proviso noting that rights may be restricted at the institution’s discretion for reasons of health and safety (Centre for Addiction and Mental Health 2004).

The back cover of a Phoenix Rising issue once suggested, “The mental health business is the only business in the world where the customer is always wrong” (1983b, PR). What happens when the customer, fed up and outraged by consistently poor service, takes a business to court and wins? In a market economy, each party in a business transaction (“legal personality”) has specific rights and responsibilities. Such “legal personalities,” which include both individuals and publicly traded corporations, can enter into contracts, incur debts and liabilities, own assets, and exercise freedom of speech by advertising their services or their desire to contract services (O’Melinn 2006; Woodworth 2009). Within this framework, dissatisfied healthcare “consumers” are entitled to contest providers’ contractual violations (e.g. they can litigate instances of medical malpractice, contest a pharmaceutical firm’s failure to disclose an antidepressant’s adverse effects, and challenge transgressions of civil rights in hospital wards). However, under the norms of a therapeutic marketplace, there is nothing inherently wrong with pharmaceutical companies’ widespread marketing of diseases and lifestyle drugs; in fact, there is arguably everything right with it. It makes information more available to consumers who are mulling their options and it enhances sales/prescriptions, thereby securing profits for public shareholders. It is, indeed, illegal for publicly traded companies such as Pfizer, Merck, Eli Lilly, and GlaxoSmithKline to place any interest ahead of maximizing shareholder value, as doing so would violate their responsibility to investors (Woodworth 2009). Under market liberalism, psychiatric consumers are entitled to information about their medications’ adverse effects, and they are even entitled to expand the definition of “legal capacity” so that they may act on this information as they wish. But they are not entitled to information about the historical origins of global capitalism and its colonial foundations, or about feminist epistemologies, critical disability theory, the metaphoricity of science, Orientalism, the anthropology of food, or the social construction of psychological categories—all of which can shape the kind of “informed consent” they exercise.
The point is not trivial. During their time in print, *Madness Network News* and *Phoenix Rising* played invaluable roles as alternative sources of cultural, economic, and historical analysis that were otherwise largely inaccessible to readers. They not only facilitated dialogue but gave voice to new understandings of crisis, suffering, and resistance that drew readers’ attentions to broader systems of injustice and made it possible for readers like Malcolm to identify anti-psychiatry and anti-capitalism as one and the same enterprise. As one *Phoenix* writer noted in the dying days of *MNN*,

> the people who put out *Madness Network News*… have been a constant source of strength, support and networking for the movement… Without their radical perspective, it is likely that many of us in the movement would lack the political analysis that links psychiatric oppression with the broad political and economic oppression in our society (McKinnon 1986: 10, PR).

In the next chapter, I examine some of the factors that have made comprehensive political analyses so rare in the mainstream; in chapter 5, I explore how politically meaningful patterns become discernible in individuals’ madness experiences when we suspend mainstream assumptions about the errant neurochemistry of “mentally ill” people. Chapter 6 will then discuss the relationship between people’s level of access to alternative socio-political understandings and their ability to recover from adverse experiences and existential difficulties outside of the medical purview. Given that psychiatrization is often an endpoint of accumulated life crises, some of which are intimately embedded in systems of structural and symbolic violence, coming to suspect that one’s “problem” may not ultimately be biological can unlock a powerful, insatiable interest in figuring out what “the problem” is. In and of itself, this interest obviously cannot free people from the material limitations that constrain their lives, often in determining or even fatal ways: political awakening was a central theme in my informants’ life narratives, but by no means was it the sole factor in their liberation from psychiatry. It is nonetheless true, as Kurt Danziger has noted, that “the recognition that existing categories, used in particular social contexts, are not natural categories but made-up categories frees people from the potential tyranny that those categories can exercise” (quoted in Brock 2006: 7). For this reason, it is clear that the bygone anti-psychiatric press made it possible for “mental patients” to share stories, discover new writings and ideas, identify social determinants of their pain, and thus restyle themselves “liberation fighters” (Lapon 1985: 6, *MNN*), revolting against institutional inequality and political injustice.

Yet a final point must be made here, in light of Warwick Anderson’s (2004: 287) observation that “the geographic ambit of conventional medical history” does not generally “extend much beyond a few sites in western Europe and the United States east of the
Mississippi.” While white anti-psychiatry activists consistently noticed and decried the low numbers of racialized participants in their movements, they continued to treat Michel Foucault, Thomas Szasz, Erving Goffman, and other Euro-American theorists as “the end-all, be-all,” so to speak, of scholarly anti-psychiatry, by repeatedly citing them, reprinting interviews with them, reviewing their books, and so on. Even after these authors were decentred on the basis that they were not speaking as psychiatric ex-inmates, an alternative canon was constructed solely from the writings of white, Euro-American voices: Judi Chamberlin, Carla McKague, even Elizabeth Packard. On the one hand, the omission of anti-colonial theorists from traditional anti-psychiatric histories might seem sensible given that Frantz Fanon, Albert Memmi, Aimé Césaire and their colleagues had never been psychiatric inmates—in the standard sense—nor was the focus of their radicalism the psychiatric institution per se. Fanon was, after all, a psychiatrist. On the other hand, these disqualifiers are not unique to them: Szasz and Laing were both psychiatrists and non-inmates, and Phoenix and Madness devoted many pages of newsprint to social issues that lay beyond institutional walls. My purpose here is not to single out grassroots anti-psychiatry activists for their racialized omissions, given that all disciplines have literary canons that demarcate what counts as foundational knowledge from what does not, most of which begin with long recitations of white male authors. Many psychiatric survivors were socio-economically marginal, and had limited time to work on their own political educations, let alone engage in inter-movement outreach, and so it is conceivable that they simply never encountered postcolonial writings in the course of their activism; or, perhaps, they never saw a need to encounter them. And yet these omissions do matter, not least because to this day—as we will see in chapter 7—white survivor activists notice, decry, and create conditions for the absence of racialized voices in their movements.

59 See Behar (1995) and McElhinny et al. (2003) for some critiques of anthropology’s own tendencies in this regard.
Chapter 4
“It Strikes Anyone”: Medical Journalism and the Construction of Crisis

1. Sounding the Alarm

1.1 The Commodification of Mental Health

Benjamin never seemed to be paying attention when he was spoken to, but he was, and on many occasions he would reply to a comment that I or another Folie à Deux participant had directed at him days or weeks after it had been made. Most meetings found him nodding off in a fat wicker chair that Ana had dragged into her kitchen just for him, or stirring his coffee pensively and leafing through a magazine while the others chatted. Once, when he expressed irritation with his computer’s operating speed, I offered to help him install a new RAM card. He looked up from his doughnut, but not directly at me, and then became reabsorbed in the *Mother Jones* article he was reading and underlining. I decided that my offer must have sounded silly, perhaps even patronizing, and so I said nothing more.

When I saw him again three weeks later, he rubbed his hands together as if anticipating an exciting new project, and declared, “Okay, let’s do it.” I had forgotten the original conversation and asked him to clarify. “Let’s go get that RAM,” he said. “Come on.”

Like Gracie, the woman who flew into occasional rages during Folie à Deux meetings and acknowledged her status as a “crazy lady” whom others gave a wide berth, Benjamin found that his inability to hew to his community’s politeness conventions could get him into trouble. For twenty years, he had worked as a technical underwriter for a major insurer, and had rarely missed a day of work. During his final few years with the company, he began getting into fights with his coworkers, who accused him of ignoring their requests and instructions; he claimed that he had always complied with the requests and instructions, but had simply grown tired of having to verbally acknowledge receipt “every single time.” He also began calling in sick once or twice a month, sometimes because he felt unmotivated, sometimes because the motivations that he did feel urged him elsewhere: to local parks, where he fed birds and sat on swing sets; to diners and indoor food courts, where he made crude sketches of fellow patrons; to a community centre, where he sat outside a seniors’ guitar class and listened to their halting arpeggios while contemplating his life. He eventually decided to take an early retirement package, having learned that his colleagues had been whispering about his “depression,” observing that he seemed “like another person,” and planning to stage an intervention. Benjamin, who had been detained in a psychiatric facility for several weeks in his early teens following an altercation with his father,
and who thus knew firsthand “how people treat you when they think you’re mental,” felt that the safety of his workplace had been compromised. Whereas his coworkers apparently feared that he was under the influence of a mental illness, Benjamin’s own interpretation of his odd behaviour was rather different: from his perspective, he had simply reached a point in his life where, “I don’t have to pretend anymore.” As he put it, working is not a millstone around my neck, but I had to look at my life and say, I’m going to be sixty years old and most of those years I’ve had to say, yes sir, no sir, and I’ve not been allowed to be myself. Am I going to die a fraud?

The mismatch between Benjamin’s romanticization of the truancy he revelled in during his career’s terminal stages and his coworkers’ worries that it signified clinical depression was striking. Not long after helping him with the RAM, I solicited his opinion on the concept of “presenteeism,” a term I had recently encountered in a Toronto Star article on the economic toll of mental illness on the Canadian economy. “Presenteeism,” the article asserted, occurs when employees’ minds are “not actively engaged” when they are at work, leading to unproductive working hours (Yew 2009a: B4). “So whatever the cost to people being absent,” the article continued, “there’s an additional cost of people being not quite right in spirit and brain and showing up for work” (Yew 2009a: B4). Benjamin read the newspaper clipping and began laughing out loud. It was the most animated reaction I had ever seen him produce.

“Most people don’t love their jobs,” he chuckled. “They’re never going to put in a hundred percent, no matter what you call them or what you do.”

* * *

In the past decade, Canadian news consumers have been treated to a series of increasingly unsettling claims. It seems that mental illness has been “taking a massive toll on” Canada’s national economy, costing us anywhere from $33 to $51 billion in “absenteeism and lost productivity” on an annual basis, “including $23 billion in medical bills, disability and sick leaves,” and the equivalent of 35 million lost workdays, since “those most at risk of mental illness are men and women in their prime working years” (Yew 2009a: B1; Picard 2008: para. 17; Nebenzahl 2008; Gordon 2007b: L4). In the province of Ontario alone, substance abuse and mental disorders have been costing the economy nearly $34 billion per year in healthcare and infrastructure expenses, law enforcement, research, and, of course, lost productivity (CBC News 2006). Canada’s situation appears to be the norm, rather than an exception: depression alone reportedly costs the United States over $30 billion annually in lost productivity, suicides and depression cost Japan’s economy $33.6 billion in 2009 alone, and “neurotic” personality traits
exact an annual toll of $1.4 billion on Dutch society (Tanner 2007: A3; Toronto Star wire services 2010: A17; Harding 2010). The worldwide situation is surely nothing less than a global crisis. Indeed, as the World Health Organization’s Director-General Margaret Chan points out, “We face a misperception that mental health care is a luxury item on the health agenda. But it costs $2 per person per year—it is one of the best buys” (Nebehay 2010: para. 3).

To put a “human face” on figures like these, the Canadian Standing Senate Committee on Social Affairs, Science and Technology (hereafter, “SSC”) 60 released a report in May 2006 entitled Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Chaired by senator Michael J.L. Kirby, this report (commonly referred to as the “Kirby Report”) described Canada’s first nationwide study of mental health and addiction services, which was based on the input of over three hundred “stakeholders” at public hearings held in every province and territory between 2002 and 2005, as well as hundreds of additional “submissions” received through two electronic forums (SSC 2006: 56, 2). The report underscored the need for mental healthcare reform by arguing not only that “mentally ill” workers represented an enormous drain on the national economy, but that “undetected mental illness” was a major source of workplace lassitude, causing “20% of the normal work time of employees” to be “not productive” (SSC 2006: 177). Among the report’s other findings were that mental illness represented a significant “financial burden” on family caregivers, who needed to be placed “at the centre” of any new service developments (SSC 2006: 30, 27); that “children who are frequently absent, failing or dropping out… need to be tagged and automatically screened for mental health disorders” (SSC 2006: 140, quoting Diane Sacks, Past President of the Canadian Paediatric Society); and that all children should, in fact, be subjected to “mental health screenings” in school (SSC 2006: 136, 140). The sole problems foreseen with such “screenings” fell into two categories: “legal roadblocks” to securing consent, and “practical roadblocks” to administering the programs (SSC 2006: 141-142). Ultimately, the federal government was urged to act, on the basis that

Those Canadians most likely to experience a mental illness are amongst those at the heart of our working and consuming population.

Mental disorders, unchecked and disabling, impair the capacity of a significant segment of our population to contribute actively to the economy. Innovation and productivity are increasingly key to economic

---

60 A permanent committee of the Senate of Canada, consisting of fourteen senators and tasked with investigating issues and evaluating spending proposals related to its assigned area of public policy. In October 2002, this SSC tabled a report on the state of the Canadian healthcare system; in October 2004, it was authorized by the Senate to continue its research on Canadian mental healthcare services, which resulted in the publication of the May 2006 “Kirby Report” discussed here (SSC 2006: xiii-xiv).
growth and prosperity. Mental disorders should be recognized as a leading source of disability among those we rely on to wield these critical levers of growth and competitiveness.

Productivity is affected both by “presenteeism”—days during which an individual is present at work but functions at less than full capacity—and by absenteeism—days during which an employee did not report to work. Mental illness and addiction are among the most important causes of absenteeism and presenteeism worldwide: a 1998 report of the World Health Organization observed that “more working days are lost as a result of mental disorders than physical conditions.”

… The value of lost productivity in Canada that is attributable to mental illness alone has been estimated at some $8.1 billion in 1998. More recently, if substance abuse is taken into account as well, that estimate grows to a loss to the economy of some $33 billion annually. This corresponds to 19% of the combined corporate profits of all Canadian companies, or 4% of the national debt. (SSC 2006: 177-178; emphases mine)

What is at stake when those who are positioned “at the centre” of mental health policy discussions are not the “mentally ill” themselves? Might “early intervention” initiatives and the ideological assumptions that validate them be problematic in ways that are not merely legal and logistical? Why does it matter when journalists, researchers, policymakers and other credentialed experts participate in the commodification of health and happiness, portraying “work” and “consumption” as definitive functions of healthy people, and worrying over the discovery that current—and future—employees don’t always work at “full capacity”? As Michael Lambek (2008: 138) has pointed out, despite the incommensurability of ethical and economic values, “We live at a time when economic value is striving mightily to subsume ethical value,” thereby setting forth nonsensically quantified definitions of notions like virtue and dignity. Indeed, while the recent conflations of psychiatric diagnosis with financial crisis and profit loss have mobilized business managers against the “epidemic” of workplace depression, exhaustion, stress and anxiety, this achievement displaces alternative readings of this “epidemic” that signal more recalcitrant problems with the structure of capitalist society and the limitations it imposes on individuals striving for dignity.

In this chapter, I reveal some of the rhetorical mechanisms that allow this displacement to occur, and show how the monetization of mental health gains credibility from the news media’s portrayal of mental illness as an agentive being that is stealing labour potential from its victims and from the nation. I first provide an overview of key trends in a corpus of 607 news items published in the five years following the release of the Kirby Report. By then considering the linguistic patterns in a representative subset of 50 news items, and using the techniques of critical discourse analysis, I argue that a coherent image of mental illness as a fiscal liability has
emerged in Canadian public discourse with the aid of a broad moral narrative about real and counterfeit people. This narrative can be broken down into a series of constituent claims, each of which achieves a commonsensical air through extensive repetition in the mass media—and each of which stands in stark contrast to the counterclaims of the psychiatric survivors whose life narratives I examine in subsequent chapters. These claims are:

- Mental illness is a malevolent and independently acting force
- that usurps its victim’s life, but is distinguishable from her authentic self,
- and from which salvation is possible only as a gift from a knowledgeable expert.
- The mentally ill therefore merit both pity and suspicion from healthy onlookers,
- who have a civic duty to watch for subtle signs of infiltration everywhere.

In what follows, I refer to the above narrative as the “changeling model,” for reasons detailed in section 3.1 below. While clearly intended to raise the consciousness of ordinary Canadians and tap into altruistic impulses, I argue that the above model reinforces, rather than combats, the stigma around psychiatrized life experiences by casting psychiatrized people as frauds in their own bodies. In addition, as will be seen in chapters 5 and 6, the fact that many people find their madness experiences (e.g. depression, suicide ideation, sensory hallucinations, obsessive compulsions, “delusional” beliefs, phobias and anxieties) pedagogically valuable and inextricable from their basic identities is entirely erased from the dominant narrative, as is the fact that many survivors trace their recovery back to their own efforts, not the efforts of doctors and scientists. However, because such counterarguments are rarely acknowledged in the mainstream news except as further evidence of illness, these erasures work to depict psychiatric survivors as uniquely pitiable and categorically Other. Psychiatrized people are thus ghettoized—politely and with well-intentioned phraseology—as a special interest group, and represented as national liabilities who threaten the civic order and urgently need to be acted upon because they do not adequately reproduce the norms of their society.

It should be noted that I do not suggest that Canadian audiences uniformly accept the above narrative. However, I do argue that this narrative dominates the national discourse on mental health, obliging critics of mainstream psychiatry to contend with each of its components whenever trying to advance their own views, and reinforcing normative institutions and bodies of expertise that have material effects on the conditions of everyday habit and thought (Brown 2003; Shore and Wright 2000). Many of the texts within my corpus portray the marriage of

involves systematic attention to linguistic features such as grammatical assignments of agency, distinctive semantic and metaphoric relationships, and lexical patterns that shape a given body of discourse (Wodak and Chilton 2005). CDA analysts consider linguistic features in relation to a text’s conditions of production and consumption, as well as the broad societal currents in which texts are embedded.
mental health advocacy, corporate policymaking, and medical—especially pharmaceutical—research as a groundbreaking new zeitgeist in current thinking about mental health. In what follows, it will become clear that the novelty of 21st century mental health discourse resides not in its impact on those who are already concerned with financial liability (employers, etc) but in its ability to get progressive writers and liberal policymakers invested in market logic, “bottom line” considerations (Gordon 2007a: L1), “value for money” approaches (Lurie 2009: IN7), and “good business sense” (Tanner 2007: A3).

1.2 Public Attitudes and the News Media

While paid newspaper subscriptions have been in steady decline over the past decade, industry researchers have found that 77% of Canadian adults read a daily newspaper every week, either in print or online (National Audience Databank 2011: 1; hereafter, “NADbank”), and newspapers remain highly respected sources of information (Baker 2007; Cotter 2010). According to a recent study conducted the Canadian Newspaper Association, Canada’s daily paid circulation stands at about 26.9 million copies in an average week, with Ontario’s share of the national newspaper market standing at 42% and Toronto alone accounting for over 20% of the national figure (Canadian Newspaper Association 2010a: 2, 4, 10; hereafter, “CNA”). Online news outlets and newswires have grown in popularity with the decline of paid subscriptions, and many of the country’s major news organizations now maintain one or more “hub” websites that are separate from their print edition’s websites but serve as umbrella sites for multiple print editions (NADbank 2009a: 2). For example, Postmedia Network, which owns the National Post, the Montreal Gazette, and the Ottawa Citizen, also publishes the hub website Canada.com, on which stories from all three print editions appear, and Quebecor Media publishes Canoe.ca, on which items from its slate of Sun newspapers appear. Approximately 14% of Torontonians access hubs for news at least once a month (NADbank 2010: 14).

---

62 The National Audience Databank Inc. (“NADbank”) is a research organization composed of three groups of stakeholders: Canadian daily newspapers, media-buying companies, and advertisers. Its website states that it “conducts research in Canadian urban markets to provide cost-effective and accurate in-depth marketing information for its members to assist in the buying and selling of daily newspaper advertising in Canada” (NADbank 2011: 4).

63 In calculating these figures, a “daily newspaper” was defined as a publication containing general news, published four or more times each week in either of Canada’s official languages (CNA 2010:19). The Canadian Newspaper Association was a non-profit trade association and lobbying group that represented over a hundred Canadian daily newspapers from June 1996 through January 2011. Its mission was to “promote the positive reputation of newspapers as an essential medium that benefits all Canadians, and as an effective vehicle for advertisers” (Newspapers Canada 2010b: para. 1). In January 2011, the CNA merged with the Canadian Community Newspapers Association to become “Newspapers Canada.” CNA continues to be represented by a separate board of directors within Newspapers Canada.
News consumption in the Toronto area is evidently high, and the contributions of mainstream news sources such as the *Toronto Star*, the *Globe and Mail*, the *National Post*, *Maclean’s* magazine and the CBC to the cultural field in which debates about psychiatry are embedded should not be underestimated. While mass communications researchers do not all agree on how, why, and to what extent public audiences are influenced by the news media (van Dijk 1996: 9, 29), rafts of linguistic studies have persuasively demonstrated that news outlets play a key role in crafting and disseminating the symbols through which readers acquire their understanding of highly charged abstractions like immigration, citizenship, terrorism, racism, military intervention, and so on (Collins and Glover 2002; van Dijk 2006; Henry and Tator 2002; Wool 2008). As communications theorist James Carey has put it, “Public opinion no longer refers to opinions being expressed in public and recorded by the press. Public opinion is formed in the press” (quoted in McCallum 2010: 154). Because the public’s attention to social issues “tracks rather closely on media coverage of those issues,” journalists also play a major role in establishing voting priorities (Kingdon 2003: 57).

It is also worth bearing in mind that the power of the news media is not strictly a matter of audience manipulation, but also involves the media’s commercial interests within the broader political economy. Most of Canada’s daily newspapers are owned by a handful of large conglomerates whose primary clientele are not news readers, but *advertisers* who pay for the right to market goods and services to a pre-existing viewing audience or readership (NADbank 2011: 4, Newspapers Canada 2010b; see also Herman and Chomsky 2002), with a particular focus on audiences aged 25-49 (“the age of acquisition,” NADbank 2009b: 1). There are thus strong financial incentives for news corporations to cultivate and maintain high readership levels, and a key method of sustaining these levels has been to focus reportage on relatively depoliticised, lifestyle-oriented themes such as entertainment, fashion, cuisine, cars, electronics, home décor and professional sports (McChesney 1999, 2008). Advertisers, moreover, will typically avoid investing in periodicals that routinely raise “serious complexities and disturbing controversies that interfere with the ‘buying mood’” (Herman and Chomsky 2002: 17). In the resultant dearth of comprehensive political or economic analysis in mainstreams news outlets (that is, analysis that covers more than just bickering legislators, parliamentary scandals, and daily fluctuations in the Dow Jones Index), deeply political issues such as mental health, racial profiling, reproductive rights, queer homelessness, child poverty, and anthropogenic climate

---

64 All of these topics are of course profoundly political in nature, but their political dimensions tend to be obscured or downplayed in mainstream news coverage.
change acquire an aura of apolitical urgency—they seem to spring out from nowhere for weeklong special reports and “feature stories,” and then fade away into nothingness with the renewal of the weekly news cycle (Cotter 2010: 145), and they consequently come to appear as though they are mostly unrelated to each other. As one American journalist put it to political theorist John Kingdon (2003: 59), “The press has the world’s shortest attention span. We don’t stick to a story for long enough to educate anybody. We move from one crisis to the next.”

The news media’s influence on public discourse is therefore dual. In addition to the fact that ordinary people rely on the media at least as much as on their healthcare providers for gaining information about health risks (Musso and Wakefield 2009: 19; see also Kleinman and Cohen 1991, Clarke and Everest 2006), editorial choices about “newsworthy” content—i.e. what to feature, what to omit and when—predetermine what kind of information they can ultimately encounter (Cotter 2010: 244). Reporters’ choices about how to craft the stories selected for each day’s edition then determine the implications, lessons, and precautionary insights that readers must contend with when following current events. As Spittalnik (1993: 296-297) notes, because journalists “form interpretive frameworks for personal decisions and entire lifestyles,” the media bear significant responsibility for shaping our moral judgements in diverse circumstances. And, as Bell (1991: 248; see also 2004) reminds us, journalists are professional storytellers who are charged not only with “knitting diverse events together” into concise narratives, but with justifying the value of their stories and revealing why certain events are reportable. Their job is to prompt their readers to reflect, more or less, on “the moral of the story” (Bauer et al. 2006: 119). And readers—even critical ones—must first develop a sense of what the moral of the story is meant to be before making determinations about how it was constructed, upon what presuppositions, in relation to what other cultural narratives, and whether it is sound.

There is a vast body of literature on the social force of words. While I locate my analysis within the tradition of critical discourse analysis, my methods owe much to the broader field of pragmatics and, in particular, the insights that have emerged from John Austin’s philosophy of language. Austin (1962) identified three main dimensions of any given linguistic production: its

---

65 The concentration of media ownership has also put the lie to the notion that Western democracies nourish a lush marketplace of ideas. As of July 2010, Canada’s ten largest media conglomerates owned 84 daily newspapers across the country (Newspapers Canada 2010a), and just as these companies have strong financial incentives to attract advertisers, they have strong incentives to retain their sponsors. Herman and Chomsky’s (1988) “propaganda model” is instructive in this regard: newspapers cannot afford to alienate major investors, and so they cannot afford to produce reportage that routinely militates against private interests. Some important work on the ways in which pharmaceutical firms, insurance companies, and other stakeholders in “the medical-industrial complex” can influence the direction of medical journalism has begun to emerge (Hartley and Coleman 2008, Relman 2007). However, a full investigation of these influences is beyond the scope of this particular chapter.
literal content (locution), what it does (illocution), and what it achieves (perlocution). For example, the DSM acts locutionarily by setting forth diagnostic criteria for bipolar disorder; illocutionarily by referencing and reinforcing a distinction between appropriate and inappropriate feelings of euphoria; and perlocutionarily by influencing the worldviews of patients and family members, and by discrediting or even disenfranchising diagnosees in broader socio-legal contexts (see Martin 2007). Likewise, a news report about a murderer who has been diagnosed with a personality disorder acts locutionarily by summarizing facts and events; illocutionarily by referencing and reinforcing a link between mental illness and physical violence; and perlocutionarily by encouraging readers to fear their “mentally ill” friends and neighbours. In this way, linguistic productions are coterminous with their material outcomes: a problem cannot be articulated without mobilizing representational tools and rhetorical conventions that always already contain hints of possible solutions and preventative measures. To recognize that all utterances contribute to, and are implicated in, long histories of social action is thus “to politicize and demythologize” the topics they describe (Myrick 1997: 42).

The terminology is not as important as the underlying point, namely that language is performative and not just representational, serving “not so much to represent features of the world, as to invite us to act upon the world as if it were configured in a specific way like that of some already known entity or process” (Bono 2001: 227, emphasis mine; see also Brown 2003; Nerlich and Halliday 2007). What I will now focus on is precisely the persuasive and dissuasive qualities of particular texts, which shape visions of the past and fears about the future, and, in so doing, motivate action in the present—rallying some people against heavily personified disease-villain entities, urging others to take prophylactic measures, and imploring still others to “do the right thing” and turn themselves over to medical custodian-heroes.

1.3 A Reminder

The American journalist Walter Lippman (1982 [1929]: 318) once observed that “the function of the moralist is not to exhort men to be good, but to elucidate what the good is.” It is precisely because journalists are key purveyors of information and opinion about public affairs to wide-ranging audiences—that is, they elucidate “the good”—that the effects of their work warrant careful scrutiny. However, as Herman and Chomsky (2002 [1988]: ix) have observed, critiques of the news media are sometimes misinterpreted as accusations of bad faith, “conspiracy theory,” or inadequate ethical insight. I wish to make clear that my aim throughout this chapter is not to indict news outlets for political partisanship, nor to single out individual journalists for using
certain phrases, expressions, or analogies in order to effect subtly calculated outcomes. My aim is to explore the ideological work that these linguistic productions perform—cumulatively and systematically—and to unpack the broader assumptions that allow this body of productions to appear normal, sensible, and inevitable. The narrow question of whether individual reporters have prejudices or ideological blinders (we all do) is not as significant to me as that of how certain social problems get constructed as singularly urgent, momentous, grave, and newsworthy, while other problems get ignored.

2. The Corpus: Size, Scope, and Rationale

2.1 Data Collection

From January 2006 through January 2011, I accumulated a corpus of 607 unique news items pertaining to mental health, mental illness, and the role of the psychiatric sciences and services throughout daily life, all of which were published in newspapers, newsmagazines, and news outlets based in or accessible in the Greater Toronto Area, with a particular focus on the Toronto Star for reasons I detail below. This corpus included articles, opinion essays, editorials, letters to the editor, interviews, special reports, advice columns, and exposés, with a notable increase in volume in the two years following March 2007, when the federal government announced the creation of the Mental Health Commission of Canada (MHCC) and tasked it with implementing the Kirby Report’s proposals. The MHCC, which was chaired by Michael Kirby himself, was assigned a mandate of four key initiatives: to launch an ongoing “anti-stigma” campaign, to devise a “national mental health strategy,” to create an online “knowledge exchange centre,” and to support research into mental health and homelessness (White 2009: 225-226). This last initiative was inaugurated in February 2008 with the federal government’s announcement that it would invest an additional $110 million into this specific aim, and was accompanied by a noticeable uptick in policy-related news stories in early 2008.

In the early stages of data collection, it became clear to me that I could not rely on online engines such as LexisNexis or Infotrac to generate a representative corpus for my analysis due to the fact that many items on topics closely enmeshed in mental health debates do not explicitly contain keywords like “mental health,” “mental illness,” or “psychiatry” (e.g. advice columns espousing evolutionary explanations for the distinct stresses that women face in life; articles glamorizing new studies on the genetic determinants of undesirable personality traits; editorials speculating about the delusional mindsets of violent criminals). To minimize the impact of this problem, and to gain firsthand insight into the range of attitudes, opinions, and beliefs about
mental health that news consumers encounter on a daily basis, I subscribed to the *Toronto Star* beginning in my pilot research period in early 2008 and ending in December 2010, shortly after the conclusion of my fieldwork. During this interval, I read the entirety of each day’s newspaper, and collected any item that addressed any topic that I judged to be substantively linked to questions of mental health. In total, I collected 367 items from the *Star*. Although this method was inevitably informed by processes of subjective interpretation, it is important to bear in mind that keyword coding is an unavoidably political task, and its political nature is not mitigated when computerized search algorithms—which are designed by people—define the parameters of a linguistic corpus, naturalizing the “definitional decisions” of human indexers (Clarke and Gawley 2009: 93) and predetermining the inclusions and exclusions that shape the ensuing study (see also Nerlich and Halliday 2007 for more on the limitations of search engines).

I selected the *Toronto Star* as a primary focus for my analysis for two reasons. First, it has the highest circulation of all Canadian national dailies by a quite wide margin (currently 20% higher than the *Globe and Mail* on weekdays and 37% higher than the *Globe* on Saturdays; Print Measurement Bureau 2011), and it has consistently held this distinction over the past two decades (Lee 1989; Rock 2005; Butt et al. 2010). Moreover, it currently has the highest combined print and online readership in Canada, and its paying readership is higher than any other daily newspaper available in the Ontario market (CNA 2010a: 15-16). It is clear that the *Star* plays a cardinal role in shaping the information consumed by large sectors of the literate Canadian public. Second, the *Star* markets itself more intensively than any other national paper as a “progressive” publication that seeks to facilitate social justice and combat injustice, “be it social, economic, political, legal or racial,” by adhering to six specific editorial principles oriented around civic responsibility (Torstar Corporation N.d.). As I hope to suggest, it is precisely because the *Toronto Star* represents itself as—and in fact is—a pillar of liberal values in Canadian public discourse that the rhetorical and evidentiary patterns that inflect the *Star*’s coverage of mental health issues actually affirm, rather than repudiate, stigmatizing attitudes toward people’s experiences of madness and illness.

Of the remaining 240 items in my corpus, I encountered 37 simply in the course of traveling, working, and living in and around the GTA; these items were from the free dailies that litter the Toronto subway system and the various lifestyle and public affairs magazines available

---

These “Atkinson Principles,” named for the *Star*’s first publisher/owner, Joseph E. Atkinson, are: “a strong, united and independent Canada,” “social justice,” “individual and civil liberties,” “community and civic engagement,” “the rights of working people,” and “the necessary role of government” (Torstar Corp. 2009: para. 6-11).
in waiting rooms, bus terminals, airports, and newsstands. The final 203 items were directed to me by my informants over the course of my preliminary research and dissertation research periods either through personal channels such as conversation and email, or the broad communicative networks through which politicized individuals routinely share information with each other (electronic mailing lists, online forums, regular group meetings). This method of data collection reflects a standard practice within politically engaged communities: when participants happen to encounter items that they find provocative, useful, compelling, insightful, puzzling, or alarming, they often forward them to others among their social networks, sometimes causing those items to gain greater publicity than might otherwise be expected based on the average circulation of its particular news outlet (Coleman 2009). Consequently, a diverse range of sources are represented within this portion of the corpus, from internationally influential and highly prestigious outlets such as the New York Times, The Guardian, and the BBC; to nationally prominent ones such as Maclean’s magazine, the National Post, and the CBC; to relatively smaller local publications such as Toronto Life, NOW Magazine, and Eye Weekly.

Aside from the Toronto Star, items from the Globe and Mail comprise a relatively high percentage of this corpus—78 out of 607 items, or 12.9%—for two reasons. First, the Globe twice issued weeklong special reports during my research period (“Breakdown: Canada’s Mental Health Crisis” in June 2008, and “Breaking Through” in November 2009), each consisting of a flurry of articles, essays, biographical profiles, and interviews focusing on the financial disaster that mental illness is said to represent for the nation. The Globe’s ongoing coverage of the national “mental health crisis” and the types of initiatives favoured by high-profile advocates was a source of amusement, intrigue, and outrage for many of my informants, and they frequently forwarded articles to each other with the addition of sarcastic quips, Marxist quotations, or simply a peeved “FYI!”. Second, more than a few of my suburban informants subscribed to the Globe and Mail, and despite their periodic misgivings about the tenor of its coverage, saw it as a sort of Canadian counterpart to the New York Times, i.e. a highly reputable journal with a centrist political orientation, whose business reportage is especially attuned to the needs of middle-class investors. Indeed, industry research consistently reveals that white-collar professionals, managers, and university graduates in Canada prefer the Globe and Mail to any

---

67 Even small publications can have readership levels comparable to national ones within their geographic area of distribution, and their effect on public attitudes within those areas should be taken seriously. NOW Magazine and Eye Weekly, two free weeklies available only in the City of Toronto, have circulation rates of 104,000 and 102,000 copies/weekday respectively, which are not dramatically lower than the National Post’s circulation rate of 162,000 copies/weekday. For comparison, the Toronto Star’s circulation rate stands at 390,000 copies/weekday and the Globe and Mail’s at 309,000 copies/weekday as of this writing (all figures from PMB 2011).
other newspaper (NADbank 2009c). Far fewer of my urban informants—who tended to be younger, poorer, more blue-collar, less formally educated, and less professionally established—had daily newspaper subscriptions, which can be prohibitively expensive to those with relatively little disposable income. However, at least five read the Toronto Star’s print edition at least twice per week, and most forwarded at least one article from the Star’s online edition to me at some point during my fieldwork.

I devote subsection 2.2 to elucidating broad patterns of ownership, circulation, chronology and content in the data I collected between 2006 and 2011. Following this, in section 3, I conduct a qualitative analysis of a representative subset of these articles in order to unearth the rhetorical mechanisms that drive what I have called the “changeling model” and unpack its social and ideological repercussions for psychiatrized individuals and Canadian society at large.

2.2 Like the Air We Breathe: Key Trends in News Coverage, 2006-2011

Michel Foucault (1980b: 197) has observed that the discourses that emerge around any given set of knowledge objects are invariably grounded in a “strategic apparatus… which makes possible the separation, not of the true from the false, but of what may from what may not be characterised as scientific.” This “apparatus,” which Foucault called the épistème, consists of all of the acts, habits, assumptions, beliefs, texts, artifacts, institutions, and iconographies in a given era that make certain discourses possible, intelligible, thinkable, and practicable while disqualifying other discourses.

Foucault’s observation places an unusual burden on media analysts. On the one hand, analyses of how particular ideological notions achieve commonsensicality at particular times and places should clearly be grounded in empirical examples that can be unpacked in rigorous detail. On the other hand, it is difficult to substantiate the existence of overarching ideological dispositions—or the omnipresence of a particular type of épistème—by reading and discussing a relatively small subset of items in isolation. Before embarking upon a more microscopic investigation, I will therefore flesh out some of the macroscopic trends that predominate in my corpus and, in so doing, draw attention to the broader events, political moments, and thematic tensions that shaped mental health reportage at the time of my fieldwork. The purpose of this exercise is not to exhaustively justify the assemblage of news items that comprise my corpus, which I acknowledge is necessarily incomplete (i.e. it does not include every single item related to mental health that was published anywhere during my research) and selective (i.e. it consists of items that were noticed and shared by my informants and by myself from news outlets that we
happened to subscribe to or encounter during those years). I would argue, however, that these 607 items are representative of the broad matrix of intersecting attitudes, controversies, ideologies, images, and cultural narratives about mental health that are available and influential in Canada today, within which contemporary debates about psychiatry and anti-psychiatry take place, and from which such debates cannot be neatly separated.

For this analysis, I coded each item for the following properties: news outlet; publication year; peg; overall subject matter (e.g. homicide investigations, fundraisers and community events, problems with the healthcare system, research into genetic determinants, promotion of somatic treatments, socioeconomic aspects, gendered aspects, introduction of screening programs and preventive initiatives, etc); any specific psychiatric diagnoses/illnesses that are focused on in the article; and to what extent individuals identified as having those illnesses get to speak in the article as opposed to being primarily or exclusively spoken about.

Figure 4.1 on the next page illustrates the number of articles that I collected each year and the relative contributions of each year’s data set to an emerging portrait of mental illness as an existential threat to the Canadian body politic. Articles advancing this position constituted half of the corpus (49.8%) and included four types of reportage: (1) stories warning readers that mental illness frequently emerges in infanthood or childhood and urging early screening and treatment; (2) stories explicitly linking violent crime and/or the risk of unpredictable violence with mental illness; (3) stories focusing on the astronomical monetary costs borne by the national economy due to rising rates of mental illness; and (4) stories that celebrate scientific research by speculating that the identification of clear biomarkers will make it possible to detect and eliminate mental illnesses. Articles portraying the “mentally ill” as possible assets to society were few and far between, and included exactly two types of reportage: stories speculating that depression may be evolutionarily advantageous, and stories linking the brilliance of major historical and artistic figures to their hypothesized/known mental illnesses. I include these items in the below chart not to suggest that this is my preferred position—as we will see in chapter 5, one does not have to romanticize an untoward experience to discern value in it—but to reveal the rarity of unambiguously positive portrayals of mental illness in the mainstream news media in comparison to unambiguously negative portrayals. Articles that did not fall into either of the

68 The event or circumstance prompting the publication of the article (Brittle and Zint 2003).

69 Riley Olstead’s (2002: 637) study of mental health coverage in the Canadian press during the 1990s similarly found that “of the 195 articles used in this research, there was not one indication where mental illness was considered anything but a negative characteristic.”
Figure 4.1  Moral Representations of “Mental Illness” in the News Media, 2006-2011

Items in the red subset linked “mental illnesses” with violent crime, widespread economic losses, worrisome tendencies that should be detected and arrested at an early age, and hypothetical biomarkers that might one day be eradicable. Items in the green subset portrayed “mental illnesses” as potential sources of creativity, intelligence, or evolutionary advantage.

Two previous categories comprised the remainder of the corpus, and chiefly included reports on psychotherapeutic drugs and their manufacturers, advice columns providing “tips” for coping with mentally ill friends and family, humour columns and slice-of-life essays, biographical blurbs, articles on policies and legal amendments, and stories about dietary aspects of mood.

It is worth pointing out that the increase in data volume represented by the February 2008 to January 2011 interval is not merely an artifact of my engagement in fieldwork during that time period but maps closely onto key events in the recent history of what the Globe calls “Canada’s mental health crisis”—which the national press has had a significant hand in constructing. The
MHCC’s receipt of $110 million in federal funds in February 2008 was followed in June 2008 by the *Globe*’s weeklong “Breakdown” series, through which the MHCC’s anti-stigma campaign was publicized. Two months later, in November, the *Globe* again devoted a set of stories to Michael Kirby’s plans for Canadians (Picard 2008). The *Star* published its own special section in May 2009 (“It Strikes Anyone”), each page of which was fringed with a sequence of decontextualized statistical tidbits, such as:

| **500,000** | Every day, half a million Canadians are absent from work due to psychiatric problems. |
| **No. 1** | Mental health is the No. 1 cause of disability in Canada, accounting for nearly 30 per cent of disability claims and 70 per cent of the total costs. |
| **$51 billion** | The estimated cost of mental illness to the Canadian economy in health care and lost productivity. |
| **5.5 percent** | While mental illnesses constitute more than 15 per cent of the burden of disease in Canada, they receive only 5.5 per cent of health-care dollars (*Toronto Star* 2009: U4). |

This litany of figures was counted as only one item in my corpus, but provided the unifying logic that allowed neighbouring news reports to feel urgent, provocative, and novel. Columnists, pundits, and letter-writers weighed in for weeks. In July 2009, the *Star* devoted substantial coverage to a policy paper chaired by then provincial Minister of Health David Caplan, beginning with an editorial claiming that “for every $1 spent on mental health and addictions, it saves $7 in health costs and $30 in lost productivity and social costs” (*Toronto Star* 2009: A12). Since then, this line has reappeared almost verbatim in a number of community publications, such as the Toronto Central Local Health Integration Network’s recent brochure on its service priorities for 2010-2013 (2009: 7). With the *Star*’s help, the Ministry’s framing of the problem has become widely influential in the local mental health advocacy community, and continues to inform debates around health services in and around the GTA.

Figure 4.2, on the page after the next, depicts the different types of diagnoses and symptoms that are featured throughout my corpus, and throws into sharp relief the extent to which psychiatric survivors’ firsthand perspectives are erased, delegitimized, and ventriloquized in narratives purporting to champion their problems. Each story in which a particular disorder played a major role was counted toward that disorder’s representation in the corpus. Some articles focused equally on multiple disorders, in which case all were counted, and some articles focused on no disorders, in which case none were counted. Remarkably, nearly a third of the articles that did focus on mental illness declined to specify any particular one, instead speaking of “mental illness” as a monolithic category (or, in some cases, “mental disorders” or “mental

---

70 Examples of the latter include: articles identifying morality, self-control, and worrying as new areas of psychiatric research; articles about unusual personality traits that rely heavily on biological reasoning but that do not frame the subject matter in psychiatrized terminology; and profiles of mental healthcare professionals.
health conditions”). Included in this subset are several articles in which discussions of “mental illness” are accompanied by recitations of multiple, seemingly arbitrary diagnoses, none of which are ultimately specified as a focus of the story (e.g. “Week by week, the committee has heard the studies, statistics and stories—from doctors, mental-health professionals, those battling addiction, autism, Alzheimer’s, depression, schizophrenia” Coyle 2009a: A20). This lexical conflation of all “mental illness” into a single construct has serious ramifications: not only does it elide the causal and contextual variability of different people’s madness experiences, it implies that this variability does not matter.

Articles were then assigned to one of four categories, depending on whether subjects identified as mentally ill exclusively speak for themselves within the text (4%), primarily speak but are also spoken about by others (3%), are primarily spoken about by others but also get to speak for themselves (20%), or are exclusively spoken about by others (73%). In nearly all cases, these “others” were either friends and family of the diagnosed individual or experts “weighing in” on the issue at hand—psychiatrists, family doctors, professors, social workers, law enforcement officials, educators, journalists, therapists, judges, and coroners—and their words and opinions comprised the greatest percentage of spoken discourse in this corpus by an enormous margin. The few articles that exclusively featured the voices of people identified as mentally ill fell chiefly into two categories: brief letters to the editor authored by people identifying themselves as mentally ill, and profiles of celebrities who have achieved a certain threshold of success (e.g. Olympic athlete Sherraine Schalm, actress Linda Hamilton of the Terminator franchise, comedian Rick Green) thereby qualifying them to speak as ‘models’ of what such people can accomplish given enough motivation to “conquer” and “overcome” (Harvey 2008: L1; Starkman 2008: S6). It is worth noting, finally, that, in articles featuring the voices of psychiatristized people alongside their observers, quotes tended to be carefully selected and framed to discredit or further pathologize them. For example:

“Why are you calling everybody?” Carey asked their mother. “I don’t want them all to see the dead cow.” In his illness, that’s how he referred to himself. (Flacks 2008: L14)

---

71 As revealed in Figure 4.2, the only two conditions for which this last category does not predominate are Seasonal Affective Disorder and Postpartum Depression, possibly because both are conceptualized as temporary conditions that do not reflect the sufferer’s “authentic” nature, thereby qualifying the sufferer to speak.

72 It is true that some of these experts might happen to also identify as sufferers of mental illness. However, if there is no indication of this in the stories for which they are interviewed, the impression conveyed is that they are speaking in their capacity as experts rather than in their capacity as psychiatristized people—and this impression is what matters.
Figure 4.2  Systematic Silencing of Psychiatrized People in the News Media, 2006-2011
Each set of stacked bars depicts who did and did not get to speak about a given condition in a corpus of 607 news items.
Starson, now 53, believed drugs would slow his thinking to normal levels and interfere with his true passion: research in physics. He had scientific formulas scribbled on his apartment walls and believed Mumbles [his pet bird] was “the force of all intelligent life.” (Tyler 2009: L4)

In the first example, a man diagnosed with depression describes himself as a “cow” while talking to mother about his suicidal feelings. Readers are then invited to see this description as bizarre and to blame the man’s illness for the overly figurative utterance, despite the fact that “mentally healthy” people refer to themselves in figurative ways all the time. The second example refers to the respondent in the Supreme Court of Canada case Starson v. Swayze (2003 SCC 32). In June 2003, the Supreme Court ruled in a 6 to 3 decision that a psychiatric patient named Scott Starson had the capacity, and therefore the right, to refuse medication. Because he was a physicist with several major publications to his name, Starson’s protestations that “his full mental functioning is critical to his scientific pursuits” (2003 SCC 32: para. 67) and that “I’ve been through these chemicals that they propose before—and I know the effects and what they want to achieve is slow down my brain” (para. 99) were taken seriously by the Supreme Court, whose majority report pointed out that it was not the side effects but “the intended purpose of the medication that he primarily objected to” (para. 101, emphasis in original). Starson’s “attending physician agreed that the purpose of the medication was to slow down Professor Starson’s brain to a normal range” (para. 99). The majority report thus concluded that, contrary to his psychiatrists’ claims, there was no basis for the contention “that a possible benefit of treatment would be the resumption of his work as a physicist. The evidence, in fact, suggests just the opposite. … It is clear that he views the cure proposed by his physicians as more damaging than his disorder” (para. 102).

Thus, the reporter’s insinuation in the above excerpt that Starson alone “believed drugs would slow his thinking” is not borne out by the documentary record. Yet, the assertion acquires a sensible feel when conjoined with the Star’s next sentence, which caricatures Starson as a madman with an untidy home and delusional theories about an oddly named pet.

Table 4.1 on the following page reveals the sources and owners of these news articles. The purpose of this disclosure is partly to provide a richer sense of the composition of this data, and partly also to demonstrate that the trends evidenced in this corpus do not primarily result from “rightwing” editorial agendas but in fact predominate in media outlets that are cornerstones

73 While this ruling has been treated as a landmark victory by Canadian psychiatric survivors, it is unclear whether its protections are extensible to patients who do not wield hegemonic markers of intellectual prowess. In chapter 7, I will revisit the ethical problems that can result when “madness” is too closely linked with intellectual ability.
Table 4.1 Origins, Ownership, and Availability of Items in a News Corpus, 2006-2011

Ownership disclosures are accurate only for the January 2006 – January 2011 timeframe, and are from the Canadian Newspaper Association (2010a:13), Newspapers Canada (2010a), a CBC news report on “Media Convergence, Acquisitions and Sales in Canada” (CBC Online, 20 April 2010), Noam 2009, and news outlets’ own editorial mastheads. It should be noted that mergers and acquisitions are ongoing even as I write: on April 4th 2011, Bell Media completed a $3.2 billion acquisition of CTV from the Woodbridge Company.

<table>
<thead>
<tr>
<th>Owner/Controlling shareholder</th>
<th>News outlet</th>
<th># Items from this outlet</th>
<th># Items from this owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOW Communications</td>
<td>NOW Magazine</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>St. Joseph Communications</td>
<td>Toronto Life</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Varsity Publications</td>
<td>The Varsity</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Eye Weekly</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Torstar Corporation</td>
<td>Thornhill Liberal</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro Toronto</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Toronto Star</td>
<td>367</td>
<td>400</td>
</tr>
<tr>
<td>Postmedia Network</td>
<td>National Post</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calgary Herald</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vancouver Sun</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Montreal Gazette</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Canada.com</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Government of Canada (CBN)</td>
<td>CBC Online</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Rogers Communications</td>
<td>Maclean’s</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chatelaine</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Quebecor Media</td>
<td>Canadian Online</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Explorer (Canoe.ca)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epoch Times Co.</td>
<td>The Epoch Times</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(Canada edition)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Edge News Co.</td>
<td>Magazine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Globe and Mail</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CTV Online</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thomson Reuters</td>
<td>7</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>newswire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New York Times</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New York Times</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Magazine</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Boston Globe</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>The New York Times Company</td>
<td>TIME Magazine</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Time Warner</td>
<td>Cable News Network</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(CNN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Washington Post Company</td>
<td>Newsweek</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Microsoft and General Electric</td>
<td>msnbc.com</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Advance Publications</td>
<td>The New Yorker</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Wenner Media LLC</td>
<td>Rolling Stone</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Georg von Holtzbrinck</td>
<td>Scientific American</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Publishing Group</td>
<td>Bloomberg</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Businessweek</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bloomberg LP</td>
<td>BBC Online</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>The Economist Group</td>
<td>The Economist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The Scott Trust</td>
<td>The Guardian</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TSL Education</td>
<td>Times Higher Education</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL 607 607
of a proudly “liberal” intelligentsia: the *Globe and Mail*, the *Toronto Star*, the *New York Times*, the *New Yorker*, the *Boston Globe*, the *Guardian*, *Scientific American*, the CBC, the BBC, and so on. The implications of this observation will be discussed later.

Content analysis is not an exact science from which axiomatic mathematical relationships can be deduced, although it can help illuminate the way in which our daily exposure to a limited number of representational conventions “can result in ideologies being so deeply ingrained in our thought patterns and language use that we take them for granted” (Mayr and Machin 2012: 10). I have elected to deploy certain kinds of quantitative metrics in the foregoing discussion to reveal conspicuous patterns that obtain throughout my data set without meaning to suggest that they obtain throughout all mental health reportage everywhere. My findings would seem to indicate, however, that current mental health reportage achieves its coherence with the aid of three underlying assumptions, which together breathe life into an unsettling portrait of mental illness as a coherent “thing” that is stealing money from Canada by sapping its citizens’ productive energies and usurping their minds, thereby making them express wishes and act on beliefs that are not their own. As suggested in Figure 4.2, people possessed by this invisible force are to be talked about and around, not to. Shaped by the illocutionary patterns captured in both Figures 4.1 and 4.2, the main assumptions that make this portrait not only intelligible, but thinkable, are:

1. “They” are a mostly undifferentiated mass of people whose chief identifying feature is that they are mentally ill. “We” are a wide range of specialized observers, and our chief identifying feature is that we are not mentally ill.

2. They cannot be trusted to speak for themselves, understand what serves their interests, or represent their own perceptions and rationales. We must make those determinations and speak on their behalf.

3. They represent only the tip of the iceberg. Mental illness is an invisible force that causes social, physical, and financial harms, and our challenge is to detect and eliminate it wherever it is found.

It should go without saying that the concept of “mental illness” is as meaningful as that of “physical illness,” about which we tend not to construct sweeping generalizations. How, then, are we conditioned to view the former, and not the latter, as a clearly distinguished group of people harbouring a special type of illness that existentially threatens the nation? What do these assumptions look like when put into linguistic practice? To answer these questions, we must pay closer attention to the material consequences of metaphor and to the rhetorical moves that sever the concept of health from the wide range of factors—and actors—that shape it.

---

74 An elite class that is institutionally positioned to shape the parameters of cultural debates, conventionally in support of individual and civil liberties (e.g. democratic elections, equality under the law, free markets, freedom of religion, freedom of the press, freedom of association; see Kingdon 2003).
3. The Thief: A Lesson in Civics

3.1 “How a Typical Teenager was Stolen Away.”

Between the medieval era and the 19th century, Western European folklore frequently featured stories about “changelings”—creatures secretly substituted for human children by supernatural beings such as gnomes, fairies, or elves. The regularity with which these beings were thought to snatch healthy children from their homes and deposit impostors in their place required mothers to exercise constant vigilance and allowed communities to disown infants who seemed listless, stunted, cantankerous, or unruly in some way, or even older children who exhibited sudden, unexplained personality changes (Eberly 1997, Leask et al. 2005). Folk narratives about these illicit exchanges described sundry methods by which victimized parents might persuade the kidnappers to return the authentic child, commonly involving the administration—with the best of intentions—of beatings, burns, or mild poisons (Munro 1997: 254-255).

Modern writers sometimes invoke the changeling myth as evidence that attitudes toward congenital disabilities have evolved radically since the dark ages due to the rise of biomedicine and the light it now sheds upon once mysterious maladies (Allday 2009). Leaving aside the problematic assumption that medieval “changelings” were necessarily the same people who today are called congenitally disabled, what is striking about the myth is how closely its defining features map on to 21st century conceptions of mental illness and those said to “have” it. The notion that the mentally ill are counterfeit entities whose true personalities must be restored from exile through the administration—with the best of intentions—of pharmaceutical elixirs and other somatic interventions serves as a fundamental organizing principle in a wide range of texts. It is a prolific metaphor, whose continual deployment allows certain political narratives to resemble received wisdom (e.g. familial negligence allows children to be whisked away by illness; the husks that are left behind are a drain on their communities; the task of modern medicine is to bring back all of these stolen/possessed people) and allows competing narratives to be not only masked but rendered inchoate, their narrators shorn of credibility.

Two kinds of qualitative analysis are undertaken in this section. I first identify a set of basic premises that appear throughout the corpus by considering their lexical and grammatical manifestations in a sample of 50 articles. Together, these premises work to naturalize and legitimize a conception of mental illness as an infiltrating force that is menacing the nation and supplanting real people. The subset of articles selected for this analysis reflects recurring trends and broad proportions in the original corpus: that is, the examples I highlight below represent,
but do not exhaust, the corpus’s full reservoir of such examples. Included are: 26 articles from the *Toronto Star*; 9 from the *Globe and Mail*; 2 each from the *New York Times, TIME Magazine*, and MSNBC.com; and 1 each from the *National Post, Metro Toronto, Maclean’s, Toronto Life, Newsweek, Rolling Stone, Vancouver Sun, CBC News Online*, and *CTV News Online*, representing a total of 26 news reports, 9 feature stories, 3 political affairs columns, 2 interviews with public figures, 2 personal essays, 2 fact sheets, 2 letters to the editor, 1 biographical profile, 1 health column, 1 book review, and 1 advice column. Out of these 50 articles, 40 were published during my pilot or dissertation fieldwork periods (2008-2010) and 10 were published prior or subsequent to my time in the field (2006-2007 and January 2011). I then conduct a critical reading of one additional article to reveal how the fragmented nature of mainstream news reportage conceals key relationships between its own facts and findings, thereby imparting depoliticised accounts of mental illness with the glow of common sense.

3.2 “I Know Now That It Was a Monster That Controlled Her.”

When poetic licence is exercised in isolation, its political effect may feel negligible. Artful turns of phrase such as “*Mental Illness Rife in Prisons*” (Brennan 2009: A15) or “*When Your Brain Can’t Say No*” (Lemonick 2009: 104) are—when encountered one at a time—relatively innocent devices that serve only to draw attention to the similarities between certain abstract concepts and certain concrete phenomena. However, when encountered in rapid succession, in steady volumes from all directions, and in relation to a consistent set of conceptual metaphors, these constructions acquire considerable ideological vitality, due not only to the similarities they highlight but the differences they suppress (Cameron et al. 1992, Lakoff and Johnson 1980: 236). While we can parcel out our experiences into discrete knowledge objects through diverse linguistic processes and, in so doing, “claim certain virtues” for those objects in support of certain empirical theories (van Fraassen 1998: 1067), we cannot peel those virtues away from the objects they define, for the two are semantically equivalent: in conventional usage, an “orbit” is not an orbit if it lacks rotational properties, and a “risk” is not a risk if nothing is at stake. In this way, language is not just representative but constitutive of our lived reality.

With this in mind, I now examine the realization of three unspoken truth claims about, respectively, “mental illness,” “the mentally ill,” and “us” in the mass media, with an eye to unveiling the cumulative ideological effects of seemingly isolated word choices. In what follows, the bracketed letters and numbers refer to the illocutionary acts indexed in each table. Whenever quoting from a headline, I cite the quotation using the name of the article’s author so that readers
can locate the corresponding entry in my Works Cited list; however, I realize that headlines are written not by reporters but by their editors. I also recognize that all of the below illocutionary acts were chosen by journalists who wished, with the very best of intentions, to capture the pain of mental illness. The fact that they consistently chose words and phrases that painted it as uncontrollable testifies to their wish to absolve sufferers of moral culpability. Yet I want to argue that these techniques, however well-intentioned, are themselves painful and alienating to “mentally ill” readers who do not see themselves as unable or unqualified to speak about their own experiences. Moreover, the changeling narrative imposes formidable evidentiary burdens on “mentally ill” individuals whose iatrogenic complaints are chronically disbelieved, both inside and outside hospital wards. I will return to this point this chapter’s conclusion and in chapter 6.

3.2.1 Know Your Enemy

The foundational premise of the changeling metaphor is that mental illness is an entity that exists and acts independently of its host. Throughout the corpus, as illustrated by the set of examples in Table 4.2 below, diagnostic labels—or monolithic placeholders like “mental illness”—serve as personified entities that stand for, and thereby conceal, heterogeneous convergences of actions, events, and priorities. Diagnoses such as depression and personality disorders are invoked as the grammatical subjects of transitive verbs and assigned a wide range of agential capacities: they are spoken of as though they possess a sentient ability to compel [A1], create [A2], thwart [A3], murder [A4], grip [A5], and otherwise terrorize their victim-objects [A6-8], and the victim-objects are frequently erased altogether from the news stories. The stories instead employ pronominal references to the reified entities in place of the human beings who are experiencing the events in question [B1-3], and the entities are described as employing various tricks and guises that clinicians must be clever enough to decipher or see through [B3, C1]. “Mental illness” is thus conflated into a distinct thing—sometimes a Puckish mischief-maker, sometimes a malevolent demon—that can be meaningfully distinguished and disentangled from the various bodies it dwells in, as well as those bodies’ historical and geographic contexts. Since it is a separate entity, we must defend ourselves from its attempts to infiltrate our lives and take over from within [C1-6]; and since we know that it does successfully conquer some of us, we mourn their loss [D1-4] and dread their supplanters [D5].

75 Other types of metaphoric discourse were present in the corpus as well (e.g. mental illnesses were occasionally likened to burns and other sources of injury, although not as frequently as they were likened to possessive agents) and I acknowledge that the predominance of one set of tropes in the corpus in no way precludes others from having systematic cultural effects.
Table 4.2
Premise I. "Mental illness" is a malicious entity that acts independently of its host.

<table>
<thead>
<tr>
<th>Illocutionary act</th>
<th>Examples</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reifying the experience and assigning agential capacities to it</strong></td>
<td>A1  A Toronto doctor accused of submitting 2,700 false OHIP claims has a complex mental illness that made her believe “kitchen table” conversations with family members were actually medical consultations.</td>
<td>Small 2009: GT3</td>
</tr>
<tr>
<td></td>
<td>A2  Personality disorders of any stripe produce toxic co-workers</td>
<td>Nebenzahl 2010: B6</td>
</tr>
<tr>
<td></td>
<td>A3  ADHD interfered with her son’s ability to learn</td>
<td>Gordon 2009: L1</td>
</tr>
<tr>
<td></td>
<td>A4  It is the most lethal of psychiatric illnesses.</td>
<td>Globe 2008a: ¶1</td>
</tr>
<tr>
<td></td>
<td>A5  As they describe the mental illness taking hold, the stories veer to chaos, to searches for help, to homelessness, jails, institutions and, too often, death.</td>
<td>Coyle 2009a: A2</td>
</tr>
<tr>
<td></td>
<td>A6  her illness dominates every moment, every relationship, every decision.</td>
<td>Belluck 2006: ¶3</td>
</tr>
<tr>
<td></td>
<td>A7  Depression Thins the Bones: Suffering from depression could predispose young women to developing osteoporosis later in life</td>
<td>Taylor 2007</td>
</tr>
<tr>
<td></td>
<td>A8  depression takes a heavy toll on the U.S. workplace</td>
<td>Tanner 2007: A3</td>
</tr>
<tr>
<td><strong>Erasing the actual people from the narrative by inserting the reified entity in their place</strong></td>
<td>B1  “If you can’t talk it down, drug it down, shock it down,” says Mayberg, “then directly tune it.” There’s one problem: nobody knows what “it” is, exactly. Despite our pharmacological, psychotherapeutic, and now targeted electrical war on depression, scientists still don’t agree on what causes it... There’s no question that depression is “in your head”; the conundrum is what has control over that head.</td>
<td>Morris 2010: ¶33-34</td>
</tr>
<tr>
<td></td>
<td>B2  [The committee] learned about depression, anxiety and other mood disorders, about autism spectrum disorders, fetal alcohol spectrum disorder, perinatal mood disorders, schizophrenia and other forms of psychosis. All of which fill the courts, the jails, the streets and the graveyards.</td>
<td>Coyle 2010: A7</td>
</tr>
<tr>
<td></td>
<td>B3  It has the most presentations, making it the most difficult to diagnose.</td>
<td>Globe 2008a: ¶3</td>
</tr>
<tr>
<td><strong>Treating the reified entity as an infiltrating force that we have to fortify our bodies and homes against</strong></td>
<td>C1  When depression came creeping into Donna Hardaker’s professional life, it wore a disguise: anger.</td>
<td>Yew 2009: U3</td>
</tr>
<tr>
<td></td>
<td>C2  This is showing us the first clear picture of new, quite bad genes entering the human genome</td>
<td>McIlroy 2010: ¶16</td>
</tr>
<tr>
<td></td>
<td>C3  The program claims to improve cognitive deficits by addressing the underlying problems: weak areas in the brain.</td>
<td>Gordon 2009: L1</td>
</tr>
<tr>
<td></td>
<td>C4  “It comes on gradually... The longer you wait, the more damage there is done.”</td>
<td>Moore 2009: ¶21</td>
</tr>
<tr>
<td></td>
<td>C5  Add more probiotics and omega-3s to your diet to boost your chances against depression</td>
<td>Milne 2011: 18</td>
</tr>
</tbody>
</table>
... half of all lifetime cases of mental-health illness begin, take root and may even be solidified by age 14.”

Treating the reified entity as something that supplants and disappears people

D1 Meds Alone Couldn’t Bring Robert Back Neugeboren 2006:17

D2 How a Typical Teenager was Stolen Away Globe 2008b

D3 The Son Who Vanished... How schizophrenia stole Jesse Bigelow away and how he managed, with luck and love, to find his way home again. Anderssen 2008: ¶6

D4 But in schizophrenics, the old, familiar personality is often obliterated. Wallace-Wells 2009: ¶10

D5 I never knew who would be waiting for me when I got home from school. Embree 2009: L5

3.2.2 They Walk Among Us

The second premise, illustrated in Table 4.3, is that once seized, the “mentally ill” are categorically different beings who cannot speak for themselves and cannot be trusted. This premise gains its footing through three main techniques: treating those who study mental illness and those who experience it as mutually exclusive categories, and axiomatically situating the reader in the first category; portraying “their” traits as analogous to animals’ and equivalent to errors; and continually reminding “us” that “they” lack the sapient faculties we take for granted.

Curiously, authors in publications of all political stripes typically wrote about “the mentally ill” as though it were impossible (or inconceivable) that their reader might be one of the people they discuss. Readers were consistently positioned on the same “side” as the writers, scientists, mental health nurses, counsellors, politicians, and law enforcement personnel who study, manage, minister to, incarcerate, and speak on behalf of psychiatrized people. This was achieved through a variety of stylistic and graphical framing devices, as well as linguistic techniques: for example, using modal verbs and hedges to suggest that it is impossible to know for certain what “the mentally ill” see, feel, and experience on a daily basis [E1-2], and consulting professionals to gain an approximation of these experiences—rather than simply asking the “mentally ill” people themselves [E3]. For example, the article excerpted for [E1], which asserts forthrightly that “It is difficult to say what the depressed person sees, but researchers’ guess is that it is similar to seeing a picture in which the contrast has been reduced,” was illustrated with a digitally altered photograph representing researchers’ speculations about “what the depressed person sees.” The photograph’s colour values are so desaturated that the
image appears swathed in a white mist (see Figure 4.3 in Appendix II). Note also the conflation of all depressed people into a single prototype through the use of a definite article (“the depressed person”). To take another example, the article excerpted for [E2] is accompanied by a photograph of a bright red apple that is captioned, “The brain recognizes ‘apple’ by the shape created by its edges” (see Figure 4.4 in Appendix II). The article goes on to state nine separate times that depressed people see the borders of objects “differently” or have “an underlying difference in the brain,” but fails to ever specify the nature of these differences. Thus, the stock photo of the apple serves no purpose—except to imply that depressed people would have trouble processing the image, unlike the Star’s presumably “healthy” readers. In the story excerpted for [E3], a psychiatrist performs a series of parlour tricks involving coins and playing cards for a Star reporter, likens the reporter’s resultant bewilderment to his patients’ “strange” mindsets, and then positions those mindsets in direct contradistinction to “logical and civilized” ones.

The net effect of these representations is to paint a picture of “them” as alien beings with whom it would be bizarre to relate too closely, and for whom we should feel pity rather than understanding. Their bodily properties—chromosomes [F1], hair follicles [F2], saliva samples [F3]—are abstracted from complicating environmental variables and treated as reliable markers of otherness, as though the owners of those bodies were laboratory animals. The phenomenological complexities of conditions like gambling, depression, and emotional sensitivity are not unpacked for their underlying philosophical or biographical elements, but treated as analogous to the experiences of lower order animals like rats and locusts [G1-3]. Like a ventriloquists’ dolls, “they” resemble real people with real voices, but, as is continually pointed out, they cannot reflect on themselves or speak for themselves [H1-4].

Table 4.3
Premise II. The “mentally ill” are categorically different and cannot speak for themselves.

<table>
<thead>
<tr>
<th>Illocutionary act</th>
<th>Examples</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaking as though the reader could not possibly be one of “them”</td>
<td>Depression Really Does Turn the World Grey, Study Shows... <em>It is difficult to say what the depressed person sees, but researchers’ guess is that it is similar to seeing a picture in which the contrast has been reduced. ... A new paper published in Biological Psychiatry this month suggests people who are clinically depressed have difficulty detecting the contrast between black and white, which means that while they’re feeling blue the world might actually look dull or grey.</em></td>
<td>Baute 2010: ¶2, 5</td>
</tr>
<tr>
<td></td>
<td>Clue Found To Depression: Sufferers See Borders of Objects Differently... <em>Startling research on the brain has found that people</em></td>
<td>Taylor 2009b: L4</td>
</tr>
</tbody>
</table>

76 This particular example stood out to me because, as a depressed person, I know that I do not see the world in this manner—and could say so, if asked.
with a history of depression actually see things differently from other people. “There’s a really fundamental difference in the way they’re perceiving things,” says researcher Dr. Julie Golomb. What it means, Golomb says, is people with a history of depression see edges, borders and sharp contrasts differently.

Writer Bill Taylor gets the treatment from Dr. Bruce Ballon, a psychiatrist who uses magic to show what it can feel like to live with mental illness. “We like talking about being really logical and civilized,” Ballon says. “But under high stress, people start thinking in very strange ways.”

<table>
<thead>
<tr>
<th>Sensationalizing “their” bodily properties</th>
<th>The scientists also found the same kind of genetic glitches in patients with autism... De novo point mutations, as they are called, are almost like typos.</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>MSNBC.com 2006: ¶5</td>
</tr>
<tr>
<td>F2</td>
<td>By taking some hairs from an individual and analyzing it for carbon and nitrogen, we can tell with 80 percent accuracy whether someone has anorexia or bulimia.</td>
</tr>
<tr>
<td>F3</td>
<td>Ogilvie 2009: GT1, GT5</td>
</tr>
<tr>
<td>Portraying “their” feelings and behaviours as comparable to those of animals</td>
<td>In the study, published today in prestigious nature journal Neuropsychopharmacology, rats were taught to gamble — receiving more sugar pellets for increasingly risky behaviour. Now here comes the major question: if a surge of serotonin makes those locusts swarm, is that because they are basically depressed the rest of the time?</td>
</tr>
<tr>
<td>G1</td>
<td>CTV News 2009: ¶3, 5</td>
</tr>
<tr>
<td>G2</td>
<td>Do Locusts Get Depressed?... When serotonin levels are low in our brains we feel—and are—depressed, which is why antidepressants such as Prozac are effective. Now here comes the major question: if a surge of serotonin makes those locusts swarm, is that because they are basically depressed the rest of the time?</td>
</tr>
<tr>
<td>G3</td>
<td>Cloud 2009: 44</td>
</tr>
<tr>
<td>Speaking as though “they” lack “our” capacities of awareness</td>
<td>“People with schizophrenia can’t advocate for themselves,” Dr. John Roder, a Toronto-based schizophrenia researcher, told CBC News. “So if Terry Fox would have had schizophrenia, he wouldn’t have raised any money for that disorder.”</td>
</tr>
<tr>
<td>H1</td>
<td>CBC News 2007</td>
</tr>
<tr>
<td>H2</td>
<td>Other patients know they have a problem; these patients insist everybody else does... Whatever the specific roots of the condition, once those environmental and genetic dice are cast, is that for the disordered personality? The short, bleak answer is often yes.</td>
</tr>
<tr>
<td>H3</td>
<td>Wright 2011: ¶1</td>
</tr>
<tr>
<td>H4</td>
<td>Changing such a co-worker’s behaviour is not easy, the authors say, especially if that person is unable to self-evaluate.</td>
</tr>
<tr>
<td>H4</td>
<td>Nebenzahl 2010: B6</td>
</tr>
</tbody>
</table>
3.2.3 It Takes a Village

The third premise, illustrated below in Table 4.4, is that as a community, we have to detect and eliminate “mental illness.” To this end, we are invited to view mental illness as a national adversary that is overpowering our countrymen [I1-2], depriving our society of their potential contributions [J1-3], and committing hideous crimes while wearing their faces [I3-5]. In the story excerpted for [I5], for example, we are unambiguously directed to view mental illnesses as killers. The article (entitled, “Illness Kills, Not Individual”) tacks back and forth between the details of a 2008 murder-suicide near Quebec City and mental healthcare professionals’ armchair hypotheses about the perpetrators’ psychological states. In the story’s concluding lines, a forensic psychiatrist urges readers “to move away from this idea that the parent killed the child… because it’s the illness that kills, not the individual.” An accompanying photograph of a sombre funeral service completes the article’s concatenation of mental illness and lethal violence (see Figure 4.5 in Appendix II).

If it is illnesses and not individuals that kill, what is to be done? Our salvation, we are told, resides in the exploits of “crusading” political leaders and “veterans” of the conflict who are depicted as waging a military campaign against mental illness [K1-2, 4, 6-7] as well as scientists “who work in the trenches” while their mute patients merely “bounce from medication to medication” [K3] like inert objects. No irony is detected in formulations like “Dr. Ewan Cameron was so driven to find a cure for schizophrenia that he subjected his patients to horrific mind control experiments funded by the U.S. Central Intelligence Agency” [K5], which appears without further comment at the outset of a CBC News fact sheet on the symptoms of schizophrenia. Because the dependent clause of this sentence is asserted as a necessary outcome of the main clause (“so driven to find a cure… that he…”), Cameron is subtly absolved of responsibility for the damage his patients sustained—permanent amnesia and incontinence—despite the fact that his primary research agenda was not “to find a cure for schizophrenia,” but to devise coercive persuasion methods for his funding agency, the CIA, as part of a behavioural engineering program that was operative from the early 1950s through the early 1970s (“Project MKUltra,” see Collins 1988). Although CBC News acknowledges that Cameron’s actions were “horrific,” it makes no mention of his equally horrific objectives, leaving the impression that his intentions were irreproachable and his experimentees’ fates merely tragic.
Like a predator that preys on unwatched children when their guardians are distracted, mental illness is represented as something that is literally abducting our future: replacing “once-promising” workers with idle shells [J1] and “erasing” [L1] billions of dollars’ worth of productivity that—as the verb choice implies—should otherwise be there. By representing the problem posed by “learning disorders” as “deficits” that we might hope to “restore” [J2], this narrative implies not just absence but loss: the “disordered” are a drain on society less for what they have done than for what they have not. Those who fail to diligently and wholeheartedly cooperate with the national effort by screening their children and themselves at every opportunity are chastised for betraying their families [L2-4], their employers [L5], and “the stewards of the country’s economy” [L1]. For, if it is “mental illness” and not its victims to which we must attribute murders and other iniquities [I3-5], not to mention vast economic losses, then concealing a mental illness is not very different from sheltering a criminal.

Here, a key point must be made. As mentioned in chapter 3, modern anti-stigma initiatives often compare mental disorders to diseases with known physiological causes (e.g. diabetes) so as to reassure audiences that “mental illness” is no different from any other illness, and there is thus no shame being “mentally ill.” However, these reassurances—which are premised on the notion that mental illness is something that we should ultimately seek to “win the fight against” (Globe 2009), “crusade against,” “envision a world without” (Schizophrenia Society of Ontario 2011: 3, 1), and “cure” (Gordon 2007a: L4; Grant 2009)—are not unconditional. There is no shame in mental illness if you behave like a dutiful citizen, agree to identify as exotically different, and turn yourself in, since refusing to do so amounts to aiding and abetting a felon that is sometimes violent, sometimes murderous, and currently stealing $51 billion dollars from Canada each year. Within this framework, there is shame in failing to exercise strenuous vigilance, in shirking one’s civic responsibilities, in refusing to comply with a treatment order. There is shame in failing to teach your children “how to recognize mental illness” before it comes for them, or in failing to root out friends who “hide or deny their symptoms” (Moore 2009: para. 1, 19) and thereby open their homes to a national menace. And if you reject the war on mental illness because you do not wish to wage war on whom you happen to be, “we” know that this is only because your words are not really your own.

77 This comparison is encapsulated by the curiously constructed headline, “Friendless Children Prone to Depression” (Maclean’s 2010), which could easily have been written without resorting to a medical reification: “Friendless Children Likely to Feel Very Sad.”
### Table 4.4

<table>
<thead>
<tr>
<th>Illocutionary act</th>
<th>Examples</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assigning it predatory or criminal characteristics</strong></td>
<td><strong>I1</strong> But her soul, riven for years by a malign duo of schizophrenic and bipolar disorders, had suffered enough, she figured.</td>
<td>Hall 2010b: A7</td>
</tr>
<tr>
<td></td>
<td><strong>I2</strong> But we know that delaying treatment gives an edge to schizophrenia—i.e., more time to wreak havoc on the brain and become more intractable. Let’s examine the fruits of the first “successful” legal battle. Schizophrenia won. “Starson” lost.</td>
<td>Beeby 2009: A10</td>
</tr>
<tr>
<td></td>
<td><strong>I3</strong> The man charged with murdering a police officer with a snowplow in Toronto and the man in Tucson who went on a rampage, killing and injuring people because he was obsessed with killing a congresswoman, seem to fit the profile of schizophrenia</td>
<td>Wright 2011: ¶1</td>
</tr>
<tr>
<td></td>
<td><strong>I4</strong> As a child, I thought my mother was a fearful monster. I know now that it was a monster that controlled her, and she didn’t have the power or knowledge to break free.</td>
<td>Embree 2009: L5</td>
</tr>
<tr>
<td></td>
<td><strong>I5</strong> Illness Kills, Not Individual… Experts Help Explain What May Drive Parents to Take Children’s Lives… “We have to move away from this idea that the parent killed the child,” she [a forensic psychiatrist] says, “because it’s the illness that kills, not the individual.”</td>
<td>Chung 2009: A7</td>
</tr>
<tr>
<td><strong>Blaming it for sapping or stealing citizens’ productive potential</strong></td>
<td><strong>J1</strong> That’s where police found Scott Starson, a once-promising electrical engineer who refused medication for mental illness.</td>
<td>Tyler 2009: L4</td>
</tr>
<tr>
<td></td>
<td><strong>J2</strong> People born with inherited learning disorders may one day have these deficits restored by medication, a top researcher at Toronto’s Hospital for Sick Children says.</td>
<td>Hall 2009: A4</td>
</tr>
<tr>
<td></td>
<td><strong>J3</strong> If Kids Have Autism, Are RESPs [Registered Education Savings Plans] Useful?…now I know and accept that my kids will probably never be able to go to university or college… a disability is a staggering load on families.</td>
<td>Griffiths 2009: L4</td>
</tr>
<tr>
<td><strong>Cheering on the champions who are leading the campaign against it</strong></td>
<td><strong>K1</strong> New Charity to Take Aim At Mental Illness… The crusading head of the Mental Health Commission of Canada, Michael Kirby, has unveiled his latest endeavour… “A national charity and a national army of volunteers are critical if we want to keep mental illness out of the shadows forever.”</td>
<td>Picard 2008: ¶1, 3</td>
</tr>
<tr>
<td></td>
<td><strong>K2</strong> Harper described those appointed, including Kirby, as “the best minds in Canada’s mental-health field today” and gave them tall marching orders.</td>
<td>MacCharles 2007: ¶7</td>
</tr>
<tr>
<td></td>
<td><strong>K3</strong> The findings confirmed in a rigorous way what psychiatrists who work in the trenches know from experience: many patients bounce from medication to medication for years.</td>
<td>Carey 2008: ¶10</td>
</tr>
<tr>
<td></td>
<td><strong>K4</strong> So familiar was the exercise that one veteran in the field felt the need to suggest that this time it’s different. “The minister’s serious about this stuff,” Tom Regehr told more than 1,000 people at the convention centre.</td>
<td>Coyle 2009b: A6</td>
</tr>
</tbody>
</table>
In the late 1950s and early 1960s—Dr. Ewan Cameron was so driven to find a cure for schizophrenia that he subjected his patients to horrific mind control experiments funded by the U.S. Central Intelligence Agency.

New Battle Plan for the Lonely War

Can We Win the Fight Against Mental Illness?

But mental illness is a matter of concern for more than just those directly affected. It is a critical task looming ahead of employers and the stewards of the country’s economy, for whom mental health is a multibillion-dollar issue... That immense economic toll, magnified through Canada’s work force, amounts to roughly $51-billion a year in costs and productivity loss, with roughly $34-billion erased in Ontario alone.

Daydreamers Do Poorly—Years Later... “With aggressive intervention, we can, hopefully, shift the trajectory.” “Our results show that you don’t just let it sit.”

Out-of-the-Ordinary Tantrums May Signal Depression... many experts agree that the way a parent handles one has a direct impact on the nature of future tantrums

Hopefully, studies such as this will help parents, teachers, and pediatricians recognize the signs and symptoms of preschool depression so they make sure young children get the help they need.

“There’s presenteeism; your body is there, but your mind is not actively engaged. So whatever the cost to people being absent, there’s an additional cost of people being not quite right in spirit and brain and showing up for work. It’s a major factor in productivity.”

### 3.3 Rehabilitating Desire

The linguistic manifestations of the changeling metaphor are of course and inevitably replete with internal contradictions, for mental illness is not literally a felon, nor do the journalists whose writings sustain this metaphor intend to do so. Intention, however, is not a prerequisite to effect. Like all conceptual metaphors, this one directs attentions to certain social events while diverting attention from others. In a cruel irony, while “mental illness” is relentlessly depicted as a categorical liability that drains the economy, it is the very bodies of “the mentally ill” that support a multibillion-dollar network of industries that allow psychiatric diagnosticians and clinicians, pharmacological researchers, pharmaceutical marketers, child psychologists, documentarians, coroners, social workers, journalists, executive directors of charities, “mental health tsars” (BBC News Online 2009: para. 22) and, of course, anthropologists to earn
comfortable livelihoods for themselves and, in some cases, resplendent profits for their employers. We tend not to notice this, however, because the cultural signifiers that legitimize “our” interventions—tidy professional personas, genteel sensibilities, meritocratic attitudes and ambitions, heteronormative priorities, charitable language, and the accoutrements of material success—are precisely those whose apparent or alleged absence disqualifies “them” from full personhood. As Hindess (2004: 26) has noted, the distinction between culturally ratified forms of success and failure is the fulcrum upon which definitions of rationality turn in liberal societies, transforming market interactions into “a powerful instrument of civilisation, inculcating such virtues as prudence, diligence, punctuality, self-control, etc.” To rehabilitate the mentally ill, we must therefore impart them with our values and configure their habits, so that they, “following only their own self-interest, will do as they ought” (Li 2007: 5, quoting Scott 1998).

I alluded earlier to some of the corporate media’s in-built practices, which have led to the compartmentalization, depoliticization, and ghettoization of “mental health” as a topic of journalistic inquiry. News items emerge and evaporate as isolated units with each renewal of the weekly news cycle, fragmenting public attentions and creating an editorial need for clearly definable Others about which simplistic explanations can be advanced—as illustrated by the overly dichotomous headlines that prevail in much mental health reportage: “Crazy, Or Maybe Just Evil” (Toronto Star, DiManno 2009), “Addiction: New Research Suggests It’s Not an Illness. It’s a Choice” (Maclean’s 2009), “A Misfortune, ‘Not a Fault’” (Toronto Star, Canadian Press 2009), and “Can a Bad Mother Help Her Nature?” (The Times, Bruton 2010). In general, news coverage of social suffering tends to be “unsustained and fragmented,” such that breaking stories “may tell us a lot about the suffering in one place at a particular time, but attention will soon shift onto something else” (Mayr and Machin 2012: 221, 117). I now consider a single example of this phenomenon, with a focus on revealing how key counterexamples and counterarguments to reigning narratives about “mental illness” get elided within the mass media system, and what this means for psychiatrized people seeking to tell their stories in liberal periodicals dedicated to “social justice” and “civic and community involvement” (Torstar Corporation N.d.: para. 7, 9).

On August 25th 2009, the Toronto Star published a feature story about a nutritional class called “Low Sugar Living” offered by a community outreach program at the Scarborough Hospital. Entitled “Program Teaches Medicated Clients How to Eat Right: Simple Exercises about Healthy Foods are Key to Avoiding Diabetes,” the story describes the program’s origins, the coordinators’ motivations, and the students’ tendency to misunderstand or misremember the
lessons they are taught. Throughout, an underlying theme is the relationship between diet, diabetes risk, and “chronic mental illness” (students are specified as suffering from depression, schizophrenia, and obsessive compulsive disorders, but the author uses this phrase to conflate all three diagnoses into a single object of intervention). The piece opens with the following paragraphs:

Lisa fidgets [M1] in her chair while studying the table. On it are food items such as bananas, eggs, rice, tuna and peas.

She leaps up [M2] and reaches for a basket of potatoes. Then, she shuffles [M3] to another table to place it with items from the same food group. After some hesitation, she puts the basket next to some vegetables.

She mumbles to herself [M4], runs her fingers through her hair and shifts [M5] from foot to foot. She’s not sure.

Moments later, the others in the class yell out: “No, no, it’s a starch.”

Of course! [M6] Lisa, which is not her real name, shakes her head.

“With this mental health problem, I lose my mind,” says Lisa, who suffers from depression and obsessive compulsive disorder. [M7]

The interactive game, with its brightly coloured foods and repetition of what makes up the seven food groups, doesn’t seem like an exercise for adults [M8], whose ages range between 30 and 70.

But for these men and women, most of whom struggle with depression or schizophrenia and have difficulty with comprehension [M9], simple and easy exercises are key to learning how to make healthy food choices [M10]. It’s an important lesson because they either have diabetes or are at risk of developing the disease (Teotonio 2009: E7, para. 1-8).

“Lisa,” whose actions are assigned verbs that specifically highlight her unrefined motor skills [M1-5], “fidgets,” “leaps,” “shuffles,” “mumbles,” and “shifts” her way through the classroom activity, which is framed as a pedagogical exercise for mentally ill adults who, unlike mentally healthy adults, lack the capacity to know and serve their own interests [M8-10]. Despite her strenuous efforts, Lisa fails the assigned task, and she laments her failure by internalizing it [M7]; a potato, as everyone knows [M6], is a starch and not a vegetable. She needs to learn.

But does she? According to the federal government, the potato “is the most important vegetable crop in Canada, accounting for 35% of all vegetable farm cash receipts annually” (Agriculture and Agri-Food Canada 2007: para. 1). The Star itself regularly refers to potatoes and other tubers as vegetables, as do many healthcare professionals (e.g. Honey 2008, Jalonick 2011: 19). My point is not to fixate on the pedantic question of how to classify potatoes, but to draw attention to the rationales whereby an event that qualifies as evidence of illness in some contexts will be completely unworthy of notice in others. Lisa has a “mental health problem,” and so her thoughts and claims are commonsensically open to doubt or recrimination; Star
contributors and nutritional experts are not typically identified as having such problems, and so they are authorized to assert without having to substantiate.

Lisa’s lapse does not go unexplained. As readers are explicitly told [M11, 17], she and her classmates lack the ability to assimilate knowledge and to understand what their desires ought to be and how they ought to achieve them:

Brockington and Bachle [the program’s coordinators] noted that many of their clients visited physicians, nutritionists and diabetic educators, but did not process the information they were given [M11]. What their clients needed [M12] was closer monitoring and constant reminders [M13] about healthy eating, so they developed the class…

… The nurses use simple language, visual exercises and interactive games [M14]. But even so, it’s a challenge keeping people’s attention for an hour [M15]. Some become drowsy because of the medications they’re on, while others are incapable of sitting still. Many have difficulty remembering things and few have the motivation to make significant changes in their lifestyles [M16].

“With these people, the more interesting you make the group, the more attentive they are,” says Brockington after a class. “But there are times when there’s a limit in their ability to understand and comprehend.” [M17]

It’s not unusual, she says, for clients to munch on chocolate bars right after sitting through an entire class on the importance of keeping blood sugars low [M18].

It’s difficult to rate the success of Low Sugar Living, but the fact that clients are shedding pounds [M19] and seeking more information [M20] after class indicates that the messages of healthy eating are getting through. (Teotonio 2009: E7, para. 15-18)

The diction in [M11] suggests that the two coordinators physically sat in on all of the indicated professional appointments, observing and “noting” with alarm their clients’ literal failure to “process the information they were given.” It is possible that they did. However, it seems more plausible that this is simply their hypothesis for why their clients appear not to be following the “healthy eating” habits they wish to impart. Because their clients lack the insight to address their own needs, it is clear that what they need is “constant” supervision [M13]. The reporter’s use of the objective phrase “what their clients needed” [M12] as the decisive answer to an unexpressed question serves to place the nurses’ opinions [M13] beyond reproach. Rather than considering any of a wide range of alternative explanations for this observation (e.g. inability to afford healthy food and fresh produce), the story alights on a standard set of canards about people with psychiatric diagnoses: “these people” are limited, listless, and unmotivated [M14-17]. They are so limited, in fact, that even after their teachers take the time to edify them about blood sugar levels, they immediately go and “munch” on chocolate bars [M18].

Leaving aside the fact that wholesome groceries may not be affordable or accessible to the program’s clients—they are assigned no markers of social identity and so there is no
conclusive indication of their economic status—it may be instructive to consider this problem in another light. Do one’s dietary choices necessarily reflect one’s ability to understand nutritional advice? Like most newspapers, the Star publishes a weekly section (“Food”) covering various culinary trends. In the year that the “Low Sugar Living” article appeared, featured stories included recipes for “chocolate Guinness cake” (14 March 2009), “chocolate chip caramel surprises” (14 December 2009), and “filet mignon with chocolate balsamic reduction” (13 February 2009) as well as a piece on a “chocolate lab[oratory]” at Ryerson University at which a chemistry professor will regale visitors with “tips for storing your chocolate… for years—if you can avoid eating it, that is” (Rempel 2009: para. 7). My point here is not that the Star upholds a double standard, for it is not unique in this regard, but that the double standard is virtually unnoticeable unless one deliberately looks for it. Since “we,” the mentally robust, are axiomatically the masters of our own lives, we can be presented with a pageant of temptations on a daily basis and revise our lifestyles as we see fit. “They,” with their tenuous grasp on reality, cannot yet be entrusted with this privilege. To heal them, we therefore teach them to uncover the thin [M19], proactive [M20] person that has lain dormant inside them all along, and observe in pride as they learn to civilize their bodies and discipline their minds.

The piece describes Brockington and Bachle’s program as a sort of pre-emptive tactic, noting that the two coordinators designed it after they “noticed that most of their clients, who struggle with depression and/or schizophrenia, were diabetic or at risk of becoming so” (Teotonio 2009: E7, para. 12). These clients, Brockington points out, “are at a higher risk of developing complications and costing the health care system more money” (Teotonio 2009: E7, para. 10). Indeed,

Many had poor eating habits, led sedentary lives and were overweight because of the psychiatric medication they were on [M21].

The link between diabetes Type 2 and schizophrenia is still being researched [M22], but the Canadian Diabetes Association lists schizophrenia and being overweight as risk factors for developing diabetes [M23].

The connection between depression and diabetes is also unclear [M24]. Research shows depression leads to poorer physical and mental functioning, so a person is less likely to follow a required meal or medication plan, placing them at greater risk of developing diabetes.

… For Amanda, 62, who struggles with depression, the classes are a “reality check.” Before she started regularly attending classes, she used to binge on sweets, especially during late afternoons. But she has learned to curb that habit. [M25] (Teotonio 2009: E7, para. 12-14, 20)

Once again, something crucial is missing from this narrative. Just thirteen months prior to its visit to the Low Sugar Living classroom, the Star notified readers about a major legal action by
Canadian psychiatric survivors. The Ontario Superior Court of Justice had ruled that six plaintiffs who had developed diabetes after taking the popular antipsychotic Zyprexa (olanzapine)—which is used to treat schizophrenia and depression—could proceed with a class action lawsuit against the Canadian wing of the pharmaceutical multinational, Eli Lilly and Co., for a share of its profits on the drug (Winsa 2008). In the Star’s coverage of this class action, it is clearly explained that the lawsuit represented nearly 600,000 Canadians who developed diabetes after taking Zyprexa and targeted Eli Lilly for improperly profiting from labels that failed to mention side effects\(^{78}\) such as diabetes, hyperglycaemia, pancreatitis, ketoacidosis, and significant weight gain. The Canadian class action was settled in June 2010, and a compensation program was implemented for affected patients. Two similar class actions in the United States in 2006 and 2007 were also successful, resulting in “a payout to plaintiffs exceeding $1.5 billion” (Winsa 2008: para. 13). Since then, Zyprexa—which is Eli Lilly’s best-selling drug, earning $4.7 billion in worldwide sales in 2007 (Eli Lilly and Company 2008: 2)—has been dispensed with a label warning users of its “tendency to cause weight gain, high blood sugar, high cholesterol and other metabolic problems” (Berenson 2007: para. 1) and Health Canada has issued a warning that atypical antipsychotics are linked to cardiometabolic problems, hypertension, weight gain, lipid and glucose abnormalities, and other risk factors for heart disease and diabetes (Weeks 2012: para. 10).

Given that weight gain is one of the most common side effects of both antidepressants and antipsychotics (see Kachur et al. 2005, Wilson 2009, Zimmerman et al. 2003), and given the Star’s very capable coverage of the Zyprexa debacle the previous year, the “Low Sugar Living” article would seem like a natural site for continuing the story. Yet, isolated from these and other revelations—which are ably covered by the Star when they arise and swiftly relegated to the dustbin thereafter—the notion that diabetes, schizophrenia, and depression are linked in ways that researchers have yet to ascertain [M22, 24] and the designation of medicated students’ dietary routines as the lynchpins of their future health [M25] seem to make good sense. The single, glancing mention of the students’ medication alongside their undisciplined habits [M21] as a possible cause of costly “complications” is the reader’s sole hint that there may be more to

---

\(^{78}\) My use of the term “side effects” here follows the pharmacological convention for identifying undesired reactions to drugs. However, as Lakeman et al. (2012) argue in the International Journal of Mental Health Nursing, the term’s intelligibility rests on the assumption that there is a functional difference between a drug’s intended and unintended outcomes. Whether therapeutic or “side,” a drug’s “effects” effect changes in its patients. It is thus highly problematic that in both professional and popular parlance, “life-threatening or life-shortening effects of drugs are considered ‘side-effects,’ rather than the serious adverse effects that they are,” and that the minimization of harm has become linguistically routinized in this way (Lakeman et al. 2012: 394).
the story. With the reinsertion of relevant background details, of course, the article’s identification of “schizophrenia and being overweight as risk factors for developing diabetes” [M23] acquires a macabre tinge: the fact that diagnosed schizophrenics are routinely prescribed (and often physically forced, see chapter 6) to consume drugs linked with metabolic disorders and obesity does imply that a schizophrenia diagnosis is a risk factor for diabetes. As my friend Olivia would often say, “It’s not us who are a threat to them. It’s them who are a threat to us.”

4. Chasing Ghosts

As we have seen, by deploying a limited number of tropes and discourses, the mainstream news media treat psychiatrized people as inert objects of expertise rather than experts in their own right. News coverage is steeped in what might be called a neurotypical gaze (Armstrong 2010), axiomatically positioning writers and readers on the same side of the magnifying lens: we are all presumed to harbour similar fears about and hopes for those we understand to be ill; to be, at most, friends or relatives of those who have been rendered mute, stolen away by their afflictions; and to worry about the fact that some people are sheltering their demons rather than doing their best to cast them out. Standing between us and a bright future in which all infants grow into “cheerful, outgoing” children (Anderrson 2008: para. 2) who then mature into “the heart of our working and consuming population” (SSC 2006: 177) is an inscrutable enemy that empties its victims of mental and intellectual potential. Like villagers on a witch hunt, we are charged with tracking and eradicating something we cannot catch, for the concept of mental illness is itself a metaphor, in which pain is likened to a pathogen because both induce involuntary effects.

Like all figures of speech, the “mental illness” metaphor invites certain imaginative comparisons while foreclosing others. Given that researchers have yet to discover biological markers for any DSM disorder and, contrary to popular belief, have yet to substantiate the claim that “chemical imbalances” are identifiable and correctable at the molecular level (Lakoff 2008; Lewis 2006a), the metaphoric conflation of madness and illness would seem premature at best. What accounts for the mass media’s prolific usage of “mental illness” as a monolithic placeholder for diverse forms of psychological and social suffering? What is masked by the continual invocations of this phrase in headlines, editorials, advice columns, and feature articles? In their own study of media discourses, Clarke and Gawley (2009: 99) found that mainstream news reports virtually never mention “social justice or equity” as crucial ingredients of mental health, in spite of a longstanding epidemiological consensus that “poorer, less educated, racialized people and women” suffer higher rates of depression (see also Stoppard and
McMullen 2003, Lewis 2006a: 134). In the absence of candid discussions about justice and dignity, the fact that some of us suffer from recalcitrant and uncontrollable mental pain may appear mysterious, and biopathological comparisons may become explanatorily attractive. By equating existential difficulties with biological illness, the “mental illness” rubric makes certain resemblances thinkable: for example, if bipolar disorder is a biological illness, etiologically comparable to cancer or diabetes, then sufferers cannot be blamed for exhibiting its symptoms.

In a neoliberal society that treats individual choice as the fulcrum of individual destiny (Gershon 2011, Bell 2010), it is understandable that a highly medicalized vocabulary has materialized around those whose actions would otherwise be deemed “poorly chosen” (e.g. absenteeism, presenteeism, impolite outbursts, etc). In such a context, to call someone “mentally ill” may be to rescue them from allegations of volitional iniquity; after all, health and illness are conditions, not choices. However, as this chapter has shown, there is a dark side to this rhetorical rescue: by relocating agency from individuals to illnesses, the changeling narrative encourages us to treat such individuals with not just compassion, but fear. If bipolar disorder is a biological illness, etiologically comparable to cancer or diabetes, then sufferers cannot be blamed for exhibiting its symptoms, whatever they may be. In the shadow of such assumptions, mental patients—unlike cancer patients—are seen as latently dangerous and potentially harmful to themselves or to others. And, as we will see, mental patients—unlike cancer patients—may thus lose their civil rights by failing to follow doctors’ orders, even when those orders incur intolerable somatic or existential harms. By repeatedly depicting “mental illness” as something that estranges victims from their authentic selves, mass media texts do not simply invite, but incite, the high level of surveillance to which deviant bodies are subject in modern societies (see Myrick 1997: 48).

Media analysts have long observed that societal priorities and journalistic strategies interleave to give a platform to certain truth claims while simultaneously suppressing others (Olstead 2002: 626; see also Cotter 2010). Just as changeling folklore necessarily omits the perspectives of the accused children, the changeling metaphor denies psychiatric survivors not only the opportunity but the right to contest allegations that they are not whom they ought to be. Not only are survivors’ critiques of and counterexamples to psychiatry’s ethical and epistemological assumptions rarely acknowledged in the press, the press’s own critiques and counterexamples are rarely acknowledged in the press (e.g. the classification of potatoes, the link between nutritional understanding and nutritional choices, the link between antipsychotics and diabetes). And survivors’ firsthand knowledge of the havoc that biomedical interventions can wreak on bodies and lives can gain no traction within a web of discourses painting those
interventions in sweepingly virtuous hues, and painting their target—the “illness… not the individual” (Toronto Star, Chung 2009)—in ominous ones.

In the next chapter, I shift my focus to survivors’ counter-narratives. In stark contrast with the claims described above, my informants tended to represent their experiences with madness and misery as inseparable from their personal identities, philosophically formative, worthwhile even if initially (or invariably) unwanted, and laden with pedagogical value, suggesting that health is not a biological endpoint but a kind of biographical performance. This is not the last we have seen of the possession trope, however. Those of my informants who had been through the psychiatric system rarely spoke of surviving or battling a medical illness; they spoke, instead, of surviving the treatments administered to them and battling the depredations of the psychiatric industries. In this context, it is true that survivors occasionally referred to feelings of involuntary disembodiment—of having had their authentic personality snatched away and replaced with a ghastly doppelgänger’s—but it was not their alleged illness that initiated this sensation; it was the biopharmaceutical and electroconvulsive interventions they endured, often against their will. When they spoke of the need for vigilance, they did not fear “illness,” but the omnipresent possibility that family members might have them involuntarily (re-)committed. And when they spoke of the national campaign to “cure” and “envision a world without” mental illness, it was with an acute awareness of its eugenic undertones.
Chapter 5
Pedagogy of the Depressed: Pain, Psychiatrization, and Prevarication

1. On Showing and Telling

1.1 “And Every Single Time He’d Twist My Words.”

Olivia took a long sip of tea, leaned back nonchalantly and gestured at her half-eaten plate of wild rice and chickpeas. “Did I ever tell you how I was introduced to creamed corn?”

We were sitting on the floor in the one-room apartment she shared with Ryan, which was furnished mainly with dozens of milk crates that doubled as bookshelves, shoe racks, laundry baskets, and chairs. Ryan didn’t look up from his meal. “Jesus, Liv. Not while we’re eating.” The sun was low and fierce in the sky, and a bright, unhurried glare was slanting painfully into their west-facing unit, as it did for several hours each afternoon. Olivia curled her lip, chuckled, and stared directly into the light as she related the story of her first hospitalization:

There was this shrink, a very thin man. Very long face. First couple of times we met, he kept accusing me of intellectualizing my problems. Like I wouldn’t face up to reality—you know, like I was coming up with these grand explanations for my little girl problems. What was my problem? My boyfriend was beating the shit out of me! But this guy, he thought I was making it up, [that it] couldn’t be true, cause I didn’t have any bruises or cuts or anything. And like, I hadn’t packed up and left yet, so the bitch must be lying, right?

So, he’s like, ((in a nasal voice)) ‘A pretty girl like you gets enough attention. Don’t be such a drama queen. Clean yourself up and get on with it.’ Cause, you know, he’s testing me—wanted me to admit I’m choosing to stay, which I was, but that’s not the point. Wouldn’t discharge me. Every time, I was telling him, ‘Listen, douchecano. There’s nothing fucking wrong with me!’ … But what had happened was, Greg [her ex-boyfriend] had called the police on me, gotten me put in a mental ward, and I was surrounded by all these male doctors who thought he was just a peach—so charming, you know. Course they believed him. Bros before hos.

… I was dumb: I thought he might actually want to do his job. So, I was trying to explain it to him, you know, ‘There are no beautiful surfaces without a terrible depth.’ ((laughs)) Shit like that. Like, just because you don’t see bruises doesn’t mean it’s not happening. And every single time he’d twist my words. His theory was—cause, like, I’d told him that when we’d first met, I thought Greg was the smartest guy I ever met. It’s true—he was very smart. So, his theory was, I thought Greg was too intellectual, and I was trying to, like, match wits with him or something—like I was rationalizing. ‘He’s so smart, I don’t deserve to be with him.’ Like only men can quote Nietzsche.

On the psychiatric ward, Olivia shared a bathroom with several other inpatients. The lock on the bathroom door had been disabled to allow the staff to monitor patients’ activities more closely, and patients eventually didn’t bother to close the door at all, since, at any moment in the middle of one’s ablutions, a nurse or doctor could come barging in. She noticed that her psychiatrist made the rounds at approximately the same time each evening, and he invariably advanced down the corridor from an angle that faced the bathroom mirror.

We weren’t allowed anything sharp or matches or anything but there was a set of razor blades in a dresser drawer. Maybe the last patient—guess no one knew about ‘em. … So, one night, I pretend like I’m
brushing my hair and Dr. Douchebag comes around. He’s coming down the hall, and where he is, he can see right in the washroom without having to come in the, you know, the room. So, I take this blade and hold it up in the light, so he can see in the mirror—like, the reflection. I can see his eyes and he can see mine. (laughs)) Takes him a second to get what he’s lookin at.

… And I’m staring, like right in his eyes, and I’m smiling—like this evil smile. He went batshit. They’re tying me to the bed, and he’s yelling and I go, ‘What’s the matter? A pretty girl like me gets enough attention!’… [The next day] we had creamed corn. A nurse fed me, cause I was still restrained. … That was when I started going crazy for real.

“God, Liv. Stop.” Ryan threw her a look, then leaned toward me. “Don’t use that. She’s got better stories.” He insisted that the incident she had just detailed made it appear as though she was “the one who’s batshit” (a colloquial term for “insane”). I assured her that her actions sounded more than understandable in light of the circumstances.

“No, I mean, he has a point,” Olivia interjected. She pushed rice around on her plate for a few moments, then firmly reformulated the problem. “It’s just—it’s hard to tell it right. You had to be there.”

*   *   *

A principal source of frustration for Olivia in the above narrative is her psychiatrist’s refusal to believe her allegations of abuse on the part of her then-partner, “Greg,” who was the one who initially had her arrested and hospitalized after initiating a physical fight with her (under the provisions of the Ontario Mental Health Act; see chapter 2). Key to this frustration is her discovery that truth claims invariably have multiple meanings in institutional contexts, only some of which are considered legitimate by those who are authorized to evaluate and decide (Good 1994, Hogle 2002). Olivia suggests that her psychiatrist, by interpreting her claims as symptoms of unreasonability (“intellectualizing,” “rationalizing,” being “a drama queen”) and treating her lack of visible injuries as conclusive evidence of this theory, saw her as a woman who had failed to perform a certain type of normative femininity and who thus ought not enjoy any credibility. Western cultural signifiers of virtuous womanhood, such as a willingness to display deference, cheerfulness, cooperativeness, and concern for others before oneself under all circumstances (Bifulco and Moran 1998, Ochs and Taylor 1996, Prior 1999), do not map neatly onto the actions she undertakes in her story, and so her psychiatrist—and, to some extent, Ryan—identifies her violation of these norms as symptomatic of a madness that requires literal suppression.

What is interesting about this anecdote is how it captures a moment in which an institution’s normative technologies break down and a subject refuses to be made docile. Begoña Aretxaga’s 1995 analysis of the “Dirty Protest” in Northern Ireland, in which imprisoned Irish
Republican Army and Irish National Liberation Army members revolted against British prison authorities by refusing to bathe or use toilets from 1978 to 1981, is instructive here. The prisoners’ tactic, which involved little more than inhabiting cells smeared with their own bodily emissions, was mocked by journalists and was, for the most part, “as incomprehensible to the general public as it was to prison officers and government administration” (Aretxaga 1995: 129). At the same time, their form of protest was undeniably fraught with symbolic significance. As Gananath Obeyesekere (1981, 1990) has observed, a symbol’s potency and versatility arises from its capacity to access, suggest, and tap into heterogeneous domains of experience across time and space. Just as the IRA’s and INLA’s blood and excreta evoked the felt pain of colonial humiliation with a visceralness that written manifestos could not, Olivia’s menacing gesture with the forbidden razor blade expressed the extent of her dissatisfaction with a vividness against which all of her verbal arguments paled. And yet, she was acutely aware that it was precisely because of her dissent’s ineffability that the danger of pathologization lurked still. “You had to be there,” she appended, as if to forestall accusations of not just irrationality, but perhaps also duplicity, grandiosity, volatility, or folly.

One of the most recurrent elements in the many conversations I had in the field was indeed the claim that to narrate a story about a stigmatized experience is inevitably to misrepresent it. On innumerable occasions, a speaker would relate an anecdote and then conclude with a qualification: “I’m not telling it right,” “It’s better in my head,” “It’s just hard to find the words,” and the routine caveat, “I know it sounds pathetic, but…”. In her book Beyond the Crazy House, Toronto psychiatrist and activist Pat Capponi (2003: 74) notes that a “distrust of words” is pervasive among people who have been in the mental health system, as “we know once the words are spoken, they can be turned against us and twisted like everything else.” As one of her interviewees observes, “Words betray what we have in our heads. The receiver hears something else, and that concerns me a lot” (Capponi 2003: 74). What do psychiatrized people mean when they stress that their words are inadequately capturing the texture of their lived experiences? What methods do speakers deploy to mitigate misrepresentation, both in their life stories and of their life stories; and what is the political value of these autobiographical ambiguities? Following Julie Livingston’s (2009: 659) treatment of stories about suicide as “a cautionary vehicle through which people contemplate and comment on what they see as the fundamental existential questions of their time,” this chapter contemplates these questions with an eye to revealing how psychiatrized people locate philosophical value in their madness experiences (e.g. depression, suicide ideation, obsessive
compulsions, sensory hallucinations, unempirical beliefs, sundry phobias and anxieties). My aim here is to advance a conception of mental illnesses as embodied states that may be more pedagogical than pathological. I first explore the “madness debuts” of several informants whose pre-psychiatrizied lives involved stressors and pressures that eventually made rage, recidivism, escapism, and performed unruliness seem more attractive than normalcy. I then unpack the inadequacy of conventional thinking about “mental illness” in which timely psychopharmaceutical intervention is said to lead organically to mental health. Because my informants’ madness experiences were meaningful to them, and because medical treatments tended to entail both the delegitimization of this meaning and the introduction of disturbing side effects, it was quite rational—and not a symptom of “poor insight”—that most eventually came to reject both medicalization and medication (see chapter 6).

The life stories that form the grist of my analysis in this chapter—as expressed during interviews, dinner table conversations, electronic correspondence, late night chats, and elsewhere—fall into three broad genres. A summary of each follows, with fuller analyses provided in sections 2 and 3.

- **Putting others’ feelings ahead of one’s own.** These stories typically described the earlier years of a narrator’s life—not always childhood, but usually the period preceding a narrator’s first psychiatrizied experiences—and detail the reasons why the narrator was obliged at that time to silently endure instances of injustice or abuse, bottle up their feelings, bite back on a lifetime of grievances, frustrations, and misunderstandings for which they had no outlet, and prioritize others’ feelings over their own. Stories of this type were most often told by women, and frequently culminated in a traumatic encounter or abrupt life change over which they had no control, which directly or indirectly served as a catalyst for narrators’ debut into “madness.”

- **Developing alternative competencies.** In these stories, narrators described how they discovered, developed and honed the skills and rituals that would, in some cases, later get them psychiatrizied or lead them into unanticipated trouble. Stories of this type also dealt with the value of these activities to narrators’ sense of identity and moral worth, as well as their irreducible necessity to narrators’ survival at that time in their lives. It is important to note that the fact that these activities and experiences were valuable in diverse ways to narrators does not mean they were necessarily always desired by them.
• Losing one’s self to psychiatry. These stories would address narrators’ initial and subsequent encounters with institutional psychiatry and the effects that somatic interventions such as pharmaceuticals (“drugs,” “meds”) or electroconvulsive therapy (“ECT,” “shock,” “electroshock”) had on their lives. Effects that narrators commonly ascribed to these interventions include: temporary or permanent loss of their authentic personalities, loss of valued personal traits or skills, loss of memory, loss of cherished friendships or kinship bonds, and diminished or extinguished likelihood of achieving certain benchmarks of material success.

• Reclaiming one’s self from psychiatry. I conclude this chapter by alluding to the turning points that enabled my informants’ recoveries outside of the medical system’s purview. Chapter 6 will explore such stories more closely by focusing on the disjuncture between medicalized conceptions of “insight,” “compliance,” and “recovery,” and psychiatric survivors’ diametrically opposed conceptions. Chapter 7 will then discuss how the experience of political awakening (a vital component of many non-medicalized recoveries) can blind people to certain forms of injustice even as it sensitizes them to others.

Several caveats are necessary here. First, it should be noted that the above genres are not necessarily chronological stages of a single type of life history narrative—that is, it is not the case that narrators invariably started out with a story from the first category and progressed linearly to the fourth, although some did. Many narrators produced stories that fell only into one or two of these categories, and many stories exhibited elements of more than one genre. Second, the above list is not exhaustive; by organizing and categorizing these stories in the way that I have, I do not mean to suggest that narrators did not tell other kinds of stories, as of course all people do. Finally, it should be noted that narrators frequently used medicalized vocabularies even when contesting the legitimacy of psychiatric discourses and practices, and this is not paradoxical given that most of them grew up in, or have been socialized into, a culture that relies disproportionately on such vocabularies to describe diverse phenomenological states (“addiction,” “depression,” “psychosis”). Toward the end of this chapter, I discuss the ways in which the availability and unavailability of alternative linguistic resources and vocabularies can itself be a factor in whether one is able to successfully consolidate and perform “mental health.”
1.2 Contested Etiologies

In chapter 4, I examined a hegemonic conceptual model that prevails in the mainstream media, which portrays “mentally ill” people as inauthentic versions of themselves, is premised on an all-too-literal conception of mental illness that highlights our culture’s “exaggerated emphasis on the biological idiom” (Bamford 2007: 49), and marginalizes alternative models that focus on its philosophical and phenomenological value. I now want to develop this last point further.

“Health,” Paul Rabinow has observed (1996: 165), “is arguably the dominant value of the contemporary world.” Indeed, population health analysts have long espoused a conception of “health” that draws from diverse theoretical paradigms, and whose determinants include social, cultural, political, ideological, environmental, geographic, and semiotic variables (Mallor et al. 2006, Marmot et al. 2008). Major governmental bodies have also embraced this understanding, in theory if not always in practice (cf. Maxwell 2011). On its website, the Public Health Agency of Canada regularly publishes position papers affirming that central determinants of health include, among other things, “income inequality,” “job security and working conditions,” “housing and food security,” “education and care in early life,” and “peace” (PHAC 2003: 1-4); and the constitution of the World Health Organization describes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 2006: 1) that requires an environment “in which physical, social and aesthetic factors are all given their due importance” (WHO 1990, cited in Musso and Wakefield 2009: 18; see also Petersen and Lupton 1996). It would appear that the notion that health is not merely a biological state but is, in fact, a socio-politically emergent process has achieved widespread recognition in both scholarly and governmental discourse.

This apparent consensus, however, smuggles in its own problems. People can choose to eschew work, housing, nutrition, friendship, family, and educational opportunities—and they can choose to embrace injury, unemployment, malnutrition, isolation and vagrancy. If the first set of variables consists of key determinants of health, does this mean that those who elect the second set are necessarily physically unwell and perhaps are already mentally unwell? Does “choosing” illness and infirmity when healthier options are available necessarily indicate a lack of understanding? It is, of course, important to distinguish between agency and that illusory ideal, “freedom.” As Janice Boddy (1998: 99) reminds us, “Even when choice seems possible, one’s economic security and personal well-being may depend utterly and irrevocably on compliance.” Nonetheless, in what follows, I consider the above questions from a number of angles and suggest that the health/illness binary, conventionally defined, is not always an appropriate rubric
for understanding such choices. I suggest, moreover, that dominant Western conceptions of “mental health” derive their coherence from idealized constructions of competence, motivation, and desire that not universally sustainable or attainable. Such conceptions, which are overdetermined by the universalizing liberal principle that “we may all be different at one level, but we all want the same things” (Friedman 2002: 29), foreclose alternative methods for surviving life’s unruliness and constrain the explanatory resources that people feel they can safely deploy.

Anthropologists have skilfully challenged these types of universalizing principles in a wide range of contexts. Holly Wardlow’s (2004, 2006) research on transgressive sexualities in Papua New Guinea deftly challenges the mainstream assumption that sex workers are invariably driven by financial desperation, revealing instead that rage, revenge, and resistance can motivate women to engage in transactional sex (see also Leclerc-Madlala 2003). Sigal Gooldin’s (2008) study of anorexic inpatients at an Israeli hospital problematizes the view that women develop eating disorders only because they have capitulated to the normative images of patriarchal femininity that saturate Western consumer culture, showing instead that some women experience their anorexia as a heroic project that allows them to resist, rather than succumb to, the demands of others. Jean Jackson’s (2003) study of chronic pain sufferers in New England advances key insights about the meaning of silence in clinical encounters, demonstrating that patients who refuse to talk about their pain are not necessarily unable to describe its ferocity in words, but can become unwilling to do so when clinicians insist on quantifying and ranking it. As this brief review suggests, an important move in medical anthropology has been to reveal how assigning well-intentioned stock explanations (material destitution, patriarchal brainwashing, inability to cooperate with doctors) to “irrational” or “unhealthy” events (exchanging sex for money, starving oneself to the brink of death, refusing to cooperate with doctors) can sometimes result in the reinscription of moralistic judgements. That is, people whose priorities and motives do not map readily onto ones that satisfy canonical standards of rationality can find themselves erased, discredited, or ventriloquized by their scholarly/activist defenders and sympathizers.

The theoretical implications of this genre of ethnographic critique for narrative analysts are dual. First, such critiques should sensitize analysts to the sometimes counter-intuitive and roundabout ways in which people attempt to gain control over untoward perceptions about their lives. Although my informants generally did not subscribe to mainstream conceptions of “mental illness,” they were aware that these conceptions represented a ready-made explanatory option—a sort of emergency exit—at moments when their stories felt unsuccessful, abortive, or
inadequately explained and they found themselves at a loss for words (sections 2 and 3 will consider some examples). Their use of this “emergency exit,” however, did not necessarily mean that they were capitulating to the logic of psychiatrization and, as I will suggest, should instead be understood as a narrative tactic that allows unusual existential grievances to resemble more traditional ones.

Second, these critiques should encourage analysts to examine the situated assumptions that inform their own gaze. As McElhinny et al. (2009) suggest, narrators who do not share the professional successes and positional privileges enjoyed by most scholarly researchers—graduate students, professors—do not necessarily create coherence within their stories using the tools and techniques that middle-class speakers tend to employ. For example, immigrants often find themselves working outside of the professions they were originally trained for, and their children may find their own career opportunities curtailed due to a lack of advantageous family connections (see also Glick Schiller and Fouron 2001). Rather than describing their current occupations as organic outgrowths of individualistic effort and achieved success, McElhinny et al.’s Filipino informants more often assigned causality to accidental life events, innate character traits, divine will, and structural limitations (2009: 98-106). In other words: not all life stories proceed upwardly along a linear, meritocratic trajectory, and to assume otherwise is to turn a blind eye to the uneven playing field. I want to suggest, in a similar spirit, that life stories need not always proceed with an expectation of success. The notion that biographical narratives are always organized in relation to a valued long-term goal whose realization is either facilitated or frustrated (e.g. career advancement, establishment of a happy conjugal household, recovery from a disease; see Robinson 1990, Riessman 2003, Sparkes 2005) assumes that narrators invariably see a future for themselves. I want to suggest that this, too, is a classist but canonical presupposition that silences certain truth claims and reinscribes the apparent stability of biopsychiatric “master storylines” that equate hopelessness, apathy, and self-destructiveness with irrationality (Ochs and Capps 1996: 33; see also Latour 1987, Mattingly 2004, Young 2004).

In the remainder of this chapter, I present case studies from my field data to flesh out the first three narrative genres previewed above. I then consider how my informants’ stories destabilize hegemonic assumptions about psychiatrized experiences—that “mental illness” is a monolithic thing that is distinguishable from its victims, that “mental health” is synonymous with participation in the capitalist economy, and that recovery requires submission to medical expertise—and affirm their right to suffer and overcome on their own terms. It should be noted that the life stories I present are drawn from continuous interviews wherever possible, but, in
nearly all cases, have been supplemented with biographical details that I learned during the sprawling late-night conversations and spontaneous social excursions that allow ethnographers to cement bonds of friendship and solidarity with those whom they meet in the field. It was, in fact, during those unrecorded (and therefore uninhibited) late-night conversations that I often learned the most about my informants’ lives—where the gaps would be filled in, so to speak, and when they would produce their most fiery denunciations of the psychiatrized economy and what it had done to their lives. Although I have tried to capture the richness of these moments, I readily acknowledge that my prose does not do justice to their eloquence.

2. Yet There Is Method In It: Madness and Its Logics

2.1 Bite Your Tongue: Putting Others’ Feelings Ahead of One’s Own

Ashley. Ashley was a passionate animal rights activist, a talented guitarist, a fan of the Palestinian hip hop artist Shadia Mansour, and a proud owner of a miniature poodle. She was also, in her words, “fat… somewhere in the 300-pound range.” For virtually her entire life, this one fact seemed to override or obliterate every other element of her identity. No one believed that she was a strict vegetarian or a kick-boxing enthusiast, as she did not resemble stereotypical images of the dainty, meat-averse waif or the toned action heroine (“Let’s be honest. Do I look like Buffy?”).79 Doctors would routinely end checkups early, dismissing her with the insistence that any and all health complaints would clear up if she would just lose weight. At the grocery store, she and her selections were regularly surveilled and critiqued by strangers in the checkout line—ice cream would elicit contemptuous smirks and rolled eyes, while carrots would elicit sympathetic smiles. No matter how hot or humid it was, she never wore shorts or sleeveless shirts. She rarely made eye contact with men, because she feared “grossing them out” with the possibility that she might be flirting with them. She was scrupulous about her personal grooming routine—hairstyling, hair removal, make-up, eyebrow shaping—in an effort to discourage her friends from suggesting, as they often did, that she “take better care” of herself.

Despite it all, Ashley described the first two decades of her life as a happy period of time. She had felt comfortable in her life, particularly due to the love and support of her father, whom she adored and who had never once hectored her about her body size. This would soon all change. When she was twenty-one years old, he took her aside and gently informed her that “he loved me and cared about me,” and this was why he could not stay silent any longer.

79 The reference is to the protagonist of the television show Buffy the Vampire Slayer (Warner Bros., 1997-2001; UPN, 2001-2003), who is indeed thin and conventionally attractive.
Everything I already knew, right? The heart disease and the cancer and—and how you won’t live as long and everything about you is wrong. I could be as beautiful outside as inside. ‘You have such a pretty face,’ blah blah blah. [Eugenia: How did you respond?] It just—how could I? I know it sounds pathetic, but he was my hero. I just took it in.

And I got really depressed, really really down for the first time. That was when I started weirding out, I think. I started hiding a lot. Didn’t let anyone take photos of me, at like family dinners and stuff. Didn’t want to be preserved that way. I pierced my eyebrow—it was—cause what it is—is—a fat chick can’t be elegant, right? But she can be hardcore punk. … I started drinking pretty hard, I was running every day. My friends said, ‘You’re not fat’—and I couldn’t fucking take it. Don’t lie to me! I live here too. Fat doesn’t mean stupid. … But dad—no—I never said anything to him.

After fourteen months of steadily worsening depression, Ashley checked herself into a psychiatric ward. “I didn’t want them to cure me,” she noted. “I just wanted to not have to deal with any of it. I never wanted to come back.” The psychiatrist who assessed her remarked that she exhibited all the symptoms of Bipolar II Disorder, started her on a prescription of the atypical antipsychotic olanzapine (Zyprexa, see chapter 4), and then added, rather nonchalantly, that her recovery would be swifter if she would commit to losing at least fifty to seventy pounds upon her discharge. Without consulting her, he then put her on a “low cal” menu. “I wanted to die,” she said. “I prayed every night for the drugs to kill me.”

**Olivia.** When Olivia first began dating Greg, he seemed sensitive and sweet. He was vocally feminist and shared many of her intellectual interests: photography, sequential art, film noir. She had developed a respiratory infection a few weeks after they’d first met, and he had delivered homemade meals and affectionate poems to her every evening until she recovered. Thus, it didn’t strike her as especially hasty or unwise when they moved into a one-bedroom apartment together only eight months later.

I felt like I couldn’t say no, cause he was doing everything right. So romantic. You know, like—you know how in all the rom coms [romantic comedies] you have these, like, sappy men who go after women who keep saying no? And when the girl says, ‘No no, I need to think about it,’ it’s not the end of the movie, it’s the beginning of the movie. So, Tom Hanks goes after Meg Ryan in every film ever and in the last five minutes, finally she’s like, ‘Yeah, okay. Yeah, I’ll give you a shot.’ That’s where we live. … I felt sorry for him. I thought, he’s a little puppy and I’ll give him a shot.

Within months, however, Greg’s romantic disposition began to acquire sinister characteristics. He started insisting that she wear make-up to bed, and he began “gaslighting”80 her by rearranging items on her desk and bookshelves or stealing money from her purse, and then

---

80 The term “gaslighting” describes situations of psychological abuse in which abusers manipulate their intended victims with misleading information or false evidence in order to make them doubt their own judgement, memory and perception. The expression was popularized by the 1944 film *Gas Light*, in which a husband tries to drive his wife insane by making minor modifications to their home’s lighting and furnishings, and insisting, when she points them out, that her memory is mistaken (Nelson 2001: 28-32).
feigning ignorance when she inquired. Although frustrated, she reasoned that he was simply reacting to the stress of sharing a living space. Indeed, her friends accused her of being unfairly judgemental of a socially awkward man who was “kind of a nerd.”

One morning, she awoke to find him on top of her; he had removed her underwear and was attempting to penetrate her. She resisted at first, but upon realizing that her resistance was not deterring him in the least, lay still and allowed him “to do his thing.”

I waited a few weeks—I needed some headspace. I didn’t know what—and then I made a total clusterfuck mistake of telling my ((makes air quotation marks)) best friend. We went to lunch, and I said, ‘Here is what happened.’ And she said, ‘No! Greg is not a rapist.’ I never called it rape. I just said—like, this is what happened. I actually felt more violated. But I didn’t want to mess up the whole day for us. You know? So I was like ((nodding)), ‘Yep, yep, I see, you’re right.’ And [I decided], ‘You know what? It’s fine. I’m not gonna talk about it anymore.’ I bottled it up. … And—oh, the other thing is, is that sometimes people are like, ‘Oh you need new friends.’ Right? ‘You need real friends.’ And it’s so not helpful, cause these were my real friends.

Greg’s abuse slowly escalated over the next year and a half until the physical altercation that led to the incident described at the outset of this chapter. Olivia spent six weeks in the psychiatric facility, during which she was put on a diet of tranquilizers and was subjected to a series of bilateral ECT treatments. She was then released back into Greg’s “care” with a fistful of prescriptions and diagnoses of Borderline Personality Disorder and Atypical Depression.

My legs wouldn’t stop shaking... My mouth was so dry, I couldn’t even wet a stamp. I couldn’t remember my own phone number. I felt like a zombie. Like I would go to the washroom and forget why when I got there. It took me a long, long time to get normal. … Greg said he couldn’t be with a lunatic and left. I was so lucky. Can you imagine if he’d stayed?

Ivy. Ivy was twenty-nine years old and lived alone in a four-bedroom house in the suburban town of Richmond Hill. Her parents, who lived in Hong Kong, owned the house and wired money to her each month to cover her living expenses. They had been intending to sell the property for years, but had been postponing the sale so that she would be able to recover from fifteen years of depression, anorexia, anxiety, and obsessive compulsive disorder in her childhood home while completing a certificate in Accounting and Finance. Her parents were scared of her, she told me with a touch of bitterness, and almost certainly ashamed as well.

She had migrated to Canada at the age of eight with her mother, father, infant brother, and paternal grandfather. Her parents’ command of English was limited, but the relatively large number of Chinese grocery stores, shopping malls, and other establishments in the Greater Toronto suburbs enabled them to live their lives almost exclusively in their native language (Cantonese) while they ran the Hong Kong-based family business from afar. Anytime they needed to access medical, governmental, financial, or other services in English, they would
simply bring young Ivy along to translate, despite the fact that she herself had not yet mastered the language.\(^8\)

Her parents had high hopes for her. Each week, she toiled through an intensive regime of piano lessons, flute lessons, Mandarin classes, and English grammar classes, and she was expected to also maintain excellent marks in school. Until the age of fourteen, she dutifully did as she was told, studied hard, practiced rigorously, and submitted assignments that would typically come back with high scores and lots of checkmarks. But in spite of the outward successes, Ivy was miserable. The exacting schedule of extracurricular programming that she endured each week was not only a source of relentless stress and anxiety, it seemed to invalidate any complaints that she might have had. Her mother routinely reminded her that most children were not nearly as lucky as her—musical instruments were expensive, after all, and how many of her Canadian-born classmates were fluently trilingual? Because she could never think of an effective counterargument to what seemed like very practical reasoning, Ivy eventually concluded that it would be unkind to continue eliciting the maternal lectures.

\[\text{I was like a gun. Do you know what I mean? Every time she said something—chk-chk—another bullet.}\]
\[\text{[Eugenia: Like a loaded gun?] Yes! I was like, ‘Are you trying to get me to explode? Cause I fucking will.’}\]
\[\text{[Eugenia: You said that?] No! I said sorry. ((sighs)) I didn’t want to see her like that. She’s my mom!}\]

At fourteen, she began staying up all night pacing in her bedroom (she was not permitted to “go out” at night or “hang out” after school with her peers) and artificially keeping herself awake with the aid of multiple cups of tea or coffee. She would cry in public, force herself to calm down, and return home as if nothing had happened. She began holding her hands under cold tap water for as long as she possibly could in order to induce pain and numbness. And, in what would prove to be a major turning point, she wrote out all of her thoughts about the churning madness she felt herself descending into—and then ate the sheet of paper she had written on.

\[\text{* * *}\]

The stressors and pressures to which Ashley, Olivia, and Ivy are subjected in the above vignettes are very different, yet all three stories offer compelling evidence that embodied experiences of injustice are key determinants of these women’s distress and despair, and all follow a somewhat similar trajectory. Namely, a woman spends a lifetime compliantly absorbing the panoptical judgements, expectations, and ambitions of others, leading to excruciating feelings of helplessness that must be repressed or swallowed—literally, in Ivy’s case—so as not to

\(^8\) This is not an uncommon arrangement in immigrant households in Canada in which children speak English more fluently than their parents (see also Munger et al. 2008).
jeopardize valued relationships. Feminist theorists have long argued that women’s bodies are conceptualized as a form of collectively owned property in Western societies (Bordo 1993, 1996; Wolf 1991). Manifestations of this concept are sundry. Total strangers feel entitled to place their hands on pregnant women’s bellies; to judge the maternal talents of women from afar; to ridicule in highly gendered terms any woman they ascertain to be poor, fat, homely, or cranky (and thus ornationally valueless); to strike up conversations with random women and expect kindness, cheerfulness, and helpfulness in return; to legislate what women can and cannot do in their reproductive lives; and, ultimately, to deny the rationality—or the existence—of women who fail to satisfy certain minimal standards of feminine authenticity. Ashley’s story is a striking illustration of this theme, particularly given that her body’s size and shape happen to function as a sort of Goffmanian “master status” that “overshadows all other personal attributes” (Gregg 2003: 127). Her physical size was in itself all the evidence that her friends and family needed to confirm that she was also lazy and pathological. No normal, healthy woman could possibly allow herself to acquire such girth and to thereby violate the aesthetic/moral standards that women are expected to uphold and safeguard at all times.

Her father’s betrayal, which was initially conveyed as compassionate medical concern (“the heart disease and the cancer”) but soon assumed the familiar rhythms of aesthetic evaluation (“You have such a pretty face”), was an especially painful blow as he had never before critiqued her in this manner. However, she reasoned that arguing back would be either ineffective or relationally costly (“He was my hero”). Instead, she began deleting herself from her family narrative by avoiding cameras, as though preferring not to leave behind any evidence of her body’s existence. She bristled at her friends’ facile attempts to comfort her (“You’re not fat”). “I live here too,” she retorted (if only to me), pointing out that she is not illiterate in the norms of society just because her body happens to violate those norms; if anything, she is more literate in those norms, having spent an entire lifetime being reminded of them. And indeed, to reassure a woman that she is “not fat” is not only to deny her the right to feel anguished about inhabiting a body that attracts critique everywhere it goes, it is to imply that, if she were fat, those critiques would be legitimate. Ashley no longer felt safe talking to anyone.

Olivia’s experience was similar in some fundamental respects. Although her abusive boyfriend was the central cause of her day-to-day anguish, the incidents that she told me most enraged her were the lunchtime conversation with her then-best friend (whose reaction to Olivia’s experience of forced sex was to pre-emptively deny that it could have been rape) and the talks with “Dr. Douchebag” (who reacted to her allegations of abuse with skepticism). The
repeated denials that she knew her own mind and memories, and the continued violations of trust that marked her every intimate relationship—with her best friend, boyfriend, and doctor—led her to the brink of a very understandable madness. No longer content to engage in philosophical repartee with her psychiatrist, she resorted to a more primal language—gesticulating with the razor blade—that was silenceable only with the aid of physical restraints, pharmaceuticals, and electroconvulsive currents.

Ivy’s story exhibits some unique features, namely the fact that, unlike any of the other Unhinged members, her family’s wealth seemed to insulate her from major risk factors that the Canadian Mental Health Association and many mental health researchers identify as key determinants of psychiatric illness: poverty, malnutrition, a lack of educational opportunities, and other forms of material marginality (see Bifulco and Moran 1998, Baer et al. 2003). However, it is precisely this fact that threatens to conceal the many stressors that she did in fact face on a daily basis: language barriers, the need to perform cultural competence on behalf of her entire family starting at an early age, and the obligation to seamlessly meld two sets of cultural scripts into one’s life. That is: be assimilated enough into Canadian society to serve as de facto interpreter and cultural navigator for one’s kin, but be sure to eschew other sorts of things that (white) Canadians supposedly do, such as slack off and socialize at inappropriate times. The ways in which econometric frameworks can sometimes mask or exclude racialized variables will be revisited in chapter 7.

A theme that routinely surfaces in narratives of this genre was that of women spending their lives scrupulously following a rule that society has set out for them—that is, tolerating disagreeable behaviours “to keep the peace” or to give others “a chance”—and dutifully absorbing the emotional toll. As Capps (1999) has suggested, women tend to be socialized into indirect or deferential communicative styles that have a double meaning: they can represent both femininity and irrationality (see also Capps and Ochs 2005; Prior 1999). By declining to confront their transgressors and by choosing instead to internalize their fury, Ashley, Olivia, and Ivy were simply performing a learned gender role (Butler 1990; see also Jack 2003). Such performances, which popular culture encourages us to view through the lens of a misogynistic stereotype—that of the woman who unreasonably expects the men in her life to be able to “read

---

82 This may also explain why women psychiatric patients consistently have a harder time persuading their doctors that they are ready be discharged (or that they should never have been hospitalized in the first place) than their male counterparts. To achieve a clean bill of mental health, women must display levels of cooperativeness and compliance that far exceed anything demanded of men (see Andre 2009, Burstow and Weitz 1988, Funk 1998, Roth and Lerner 1974, Roy 2004).
her mind” and becomes hysterical when they cannot—reveal the extent to which “psychological disorders are interactional achievements” that have no existence independent of the ongoing evaluations of psychologically “normal” people (Capps 1999: 83). Brewis et al. (2011: 492) has likewise contended that illness stigma must be understood as a discrediting process “in which one’s standing as an immoral person is located within everyday interactions and relationships.”

Tanya Titchkosky (2003: 224) has pointed out that “the first social step that must be taken if we are to treat someone as mentally incompetent is to deny him or her a confirmation of her or his experience of the world.” Put more crudely, a person learns that she is crazy when other people respond to her as though she is crazy—insisting that she is making a big deal out of nothing, refusing to ratify her perceptions of untenable stress or frustration, and so on. However, the fact that no one seems to agree with her identification of an unbearable situation does not mean that the situation suddenly becomes bearable. It means only that she will be obliged on a daily basis to choose between asserting that she is, in fact a reliable witness to her own life (and potentially disrupting the serenity of valued relationships) or keeping quiet and swallowing her anger (and definitely keeping the peace).

2.2 Heroes and Outlaws: Developing Alternative Competencies

Melinda. Melinda initially did not wish to tell me the details of how she came to identify as a psychiatric survivor. “It’s not what it sounds like,” she had cautioned. To a limited extent, I knew—or I thought I knew—what she meant, for I used that very phrase with some frequency in my own personal life, and so I did not press the matter. Opportunities to become better acquainted with her were limited, as I saw her only irregularly over the course of my fieldwork year, and she declined to provide me—or anyone, in fact—with any sort of contact information. She was not on the Unhinged listserv and, whenever she attended meetings, she stuck to herself, rarely glancing up from the pad of blue-lined graph paper that she was always scribbling in, always seated next to Olivia. During the “go-arounds” that marked the start of each meeting, she typically produced only a word or two. “Melinda,” she would say, flashing the group a smile and a curt nod before returning to her poem or sketch. Twice, she requested that I deactivate my audio-recorder for the duration of a meeting, even though she did not speak during those meetings and did not object to my presence or research agenda.

It was not until the very end of my fieldwork, when the Unhinged group no longer existed (see chapter 7), that she volunteered any part of her life story to me. It was a chilly September night, and I was heading home on the subway train without the benefit of any sort of
reading material. I was whiling away the minutes between stations by sliding my gaze over everything and nothing in particular—the advertisements, the empty soft drink containers strewn around the floor, other passengers—when I suddenly found myself staring Melinda in the eye. She was seated at the far corner of the half-filled car, and was looking directly at me. Immediately, she averted her gaze. My instinctive reaction was to walk over and greet her; I had not anticipated encountering her again due to the dissolution of Unhinged and it occurred to me that I might not have a chance to see her again. But I thought better of it. The reticence she had displayed over the year, her somewhat aloof manner, and her repeated declinations to talk to me all suggested that a more respectful course of action would be to honour her boundaries and leave it at that.

Ten or fifteen minutes elapsed and I was beginning to nod off when I suddenly noticed that she was standing right in front of me. “Do you want to get a quick coffee?” she said. I of course replied in the affirmative. We exited at the next station and made our way to a nearby Second Cup. After purchasing our beverages and finding a table, she told me that there were some things she wanted me to include in my dissertation, and so I unzipped my backpack to retrieve my audio-recorder. “No,” she said, grabbing hold of my wrist. “Just write it down.” I assured her that she would do a much better job of telling her own story than I would. “It doesn’t sound right when I tell it,” she insisted. “I want you to tell it.” I agreed to listen and take notes.

Her mother had died when she was four or five. Her father never spoke of her again after the burial; indeed, although she had lived with both parents until her mother’s death, Melinda candidly asserted that she did not even remember that she had ever had a mother until she was sixteen. By the age of nine, she had lived in four different cities—Sudbury, Windsor, Detroit, and Montreal—and attended five different schools. Her father was a welder who worked irregularly but spent most of the workday “outside,” leaving Melinda and her older sister in the care of their trusty television set when they arrived home from school. She had few friends and rarely lived anywhere long enough to develop lasting bonds, and so, over the next few years, she spent most of her lunch and recess hours wandering the school grounds, pretending that she was a character in the fantastical universes she saw on the small screen—an engineer serving aboard the Starship Enterprise, an anthropomorphic falcon who accompanied Scrooge McDuck and his companions on their adventures, a ThunderCat, a doctor stationed at the 4077th MASH who was having a scandalous affair with Hawkeye Pierce, a police detective who helped the Ninja Turtles
(and occasionally Matlock) solve perplexing crimes—and generally having a good time inhabiting her imaginary worlds, as in fact many children do.83

Her father found a job in Toronto when she was fourteen, and she began high school. The fantastical exploits did not end. Most schooldays found her lost in an ecstatic world inside of her head, in which she enjoyed abilities and adventures that were inaccessible to other inhabitants of the humdrum real world. She was a commando, a sorceress, a superheroine, a warrior, an assassin, a scientist, a rock star, a treasure hunter. The cruelty of her adolescent years—during which she was alternately bullied and ignored by her classmates—served only to intensify the fantasies. When a classmate called her “too ugly to live,” she envisioned herself smashing him into a bloody pulp with a medieval mace (“with poison spikes” for good measure). When teachers chastised her for truancy or inattention, she would avenge herself by devising elaborate plotlines requiring her to humiliate them in single combat. When a group of teenaged boys catcalled her from a passing vehicle, she imagined burning them into skeletal embers with her newly discovered pyrokinetic powers. In none of these instances did she react physically or produce even a verbal rejoinder. She had no need to. In the world inside of her mind, she was invincible.

Unfortunately, things were not progressing as smoothly in the world outside of her mind. In the early 1990s, Ontario was in a severe structural recession: between 1989 and 1991, provincial unemployment rates had doubled to a total of 538,000 and would peak at around 1.4 million in 1994 (Maxwell 2009: 9). Amid this economic downturn, Melinda’s father lost what he had thought was a stable job at an automotive assembly plant; to make things worse, her older sister became pregnant soon afterward. Her father, her sister, and her sister’s boyfriend began having nightly screaming matches, which occasionally turned into shoving matches or worse. Melinda’s imaginary friends—no longer derivatives of syndicated television shows but original characters of her own design living in a magical, mountainous landscape to which she retreated during domestic disputes—seemed to feel that she should escape the toxic environment (“they wanted out”) and she concurred. She dropped out of school, and began working a steady stream of entry-level jobs in order to pay the rent on a one-room basement apartment: she waited tables, took fast food orders, mopped the floors of supermarkets, cleaned offices, and stocked coolers. Whenever she felt depressed or desperate, the characters in her mind cheered her up, joked with

her, trained her, debated with her, and urged her to challenge herself ("They’re my friends. They are as real to me as you are."). Fickle or unfair supervisors met the same imagined ends as her schoolyard tormentors and teachers.

One afternoon, she made the mistake of mentioning—in a somewhat offhand way—the conflicting opinions of the “people in my head” to a career counsellor that she occasionally saw at a local community centre. The counsellor immediately sat up, paying renewed attention to her every word. At the end of the hour, he asked if she heard voices, and she replied in the affirmative (“Of course I heard voices. When people talk to you, you hear voices!”). He then gently but firmly insisted that Melinda return to see him the next day. When she did, the counsellor led her by the hand to a small room where a smiling woman introduced herself as a community mental health nurse.

“I froze up,” Melinda said. “I was afraid. All of a sudden, I realized—it really hit me—that I was in real danger.”

“What did she say to you?” I asked. “What happened next?”

For about ten seconds, she appeared to be concentrating very hard. “Nothing happened,” she eventually replied without taking her eyes off her empty paper cup. “It’s not that—it’s—I mean—okay.” Another pause. “Forget it,” she said. “Forget it. I’m crazy.”

She then looked up at me, as if to make sure I was getting this. “I’m just crazy, okay? That’s all.”

**Ivy.** After ingesting her handwritten note, Ivy began to experience the world differently. Specifically, she began to feel as though her body were permeable to invisible forces and substances that she detected all around her.

((sighs exasperatedly)) It’s really hard to explain! You know how some people thinks everyone has a soul? I was feeling like every time I would breathe, I was sucking in all these souls. But not people souls—like this cup has a soul, or the sofa, or—you know, sometimes when I went into a building, I had to hold my breath cause I didn’t want to suck in everything in the building. [Eugenia: You thought you were absorbing—] Yeah, absorbing! ((makes a sucking noise)) Things.

Like if I walk past a garbage [waste receptacle or dumpster] I thought, ‘I better not breathe in all that garbage.’ Or like a graveyard. ‘Shit, I’m breathing in corpses!’ It’s just something I was up to. I don’t know. Do you know what I mean?

Ivy developed a logic for managing the potential contamination that she felt lurked everywhere. If inhaling meant that she was absorbing “souls” and impurities, exhaling meant that she was cleansing them from her body. Holding her breath as she entered a building would forestall the infiltration of the filth it contained. Washing her face and limbs repeatedly—but only with the
coldest available tap water—would help to fortify her body’s natural defences. She imagined that she could project green sheets of energy from her fingertips that would pass through objects and dispel them of the polluting forces they concealed.

I felt really really good. I was a pro at it. I was really proud of myself. … One time, my mom was like ((speaking in Cantonese)) ‘Wai! Le dim gai yung gun daw sui ah?’ [Translation: ‘Hey! Why are you using so much water?’] It kind of pissed me off. Like, why’s she getting on my case? You know? I said, ‘Uk kei gun wu tzo. Ngaw yung sui, ng duk meh?’ [Translation: ‘The house is so dirty. What, I can’t use water?’] [Eugenia: What did she say?] She slapped the shit out of me! [Eugenia: She hit you?] Yeah! But actually actually basically it was good. Cause then I was like, ‘Fine. Good job! You think I’m gonna waste any more time on you?’

With this turn of events, the insular world of schoolwork and homework that Ivy had occupied became physically insufferable. She redoubled her ritualistic cleansing efforts. The invisible souls and green energy sheets became the organizing mediums of her daily routine: she carefully budgeted forty-five minutes each morning and night to purifying her bedroom and herself (mainly by conjuring the green energy sheets and repeatedly exhaling through her mouth), and began making after-school detours to specific structures and landforms in her neighbourhood (a children’s jungle gym, a particular pine tree, a park bench) that she would touch to discharge the impurities accumulating inside of her. Her flute, which she was never able to clean to her satisfaction, was a particularly potent source of filth.

Cause all the spit was stuck in there. Years of spit, years and years. [Eugenia: You had saliva in your flute?] No! ((sighs in irritation)) The—you know what I mean. All the spit I already washed out was all still all in the flute. In the flute. No, no. ((sighs)) Not in the flute; in the silver.

To her parents’ rage, she began practicing the tainted instrument less and less. Her grades began to decline. She began to eat less (“I didn’t want so much stuff inside”). But, she told me, “I felt safe.” She underscored this point when I asked her whether she ever revealed the motivations behind her inordinate water usage to her parents:

Are you kidding me? ((chuckles)) My whole life, all they want to do is use me. They don’t give a shit what I think. They’re like, ‘What’d that guy say?’ and I tell ‘em [translate for them], and they’re like, ‘That’s not what he said.’ Okay—why’d you even ask me? Do you know what I mean? I felt like—I had like—it was like—you know how that saying goes? Like, a gift and a curse. They woulda gotten me locked up! [if she had told them.]

**Ryan.** Ryan often explained that a confident demeanour was the key to successful shoplifting. A thief should browse the aisles of his target grocery, convenience store, drugstore, or clothing retailer the way any other customer did—examining the merchandise for defects, noting prices and expiry dates, leafing through books—and then he should simply take whatever he wanted. “Just pick it up and walk out.” The sort of insouciance required to get away with it, however, was a developed skill—a craft—that novices attempted at their own risk. When veteran
shoplifters got caught, Ryan insisted, it was only ever because they had “gotten sloppy” and neglected to follow their own rules. As was the case with any learned technique, overconfidence was fatal. The main “rules” that Ryan had learned through years of inductive effort were:

- Never look up when you’re selecting an item from a shelf and removing its packaging. Your every motion should appear—should feel and be—natural and normal. If your body language is wrong, do not steal the item.
- Anti-theft devices do not necessarily have a common look. Before exiting, remove every removable layer with the desired piece of merchandise: boxes, metallic labels, magnetized adhesive strips and squares of paper, and so on. Do all of this confidently, not in a sneaky or paranoid manner.
- Never bring ID with you. If you happen to have ID with you, try to resist the urge to shoplift.
- Most cameras are either fake or unmonitored. Flesh-and-blood employees are the ones that merit a wide berth.
- There are no foolproof anti-theft systems.
- Don’t be greedy. If you came for five items and were able to lift only four before arousing suspicions, be satisfied with those four and leave.
- Put as much distance as you can between you and the scene of the crime as soon as the crime has been completed.
- *Your past success rate means nothing.* You must not allow past successes to lull you into present complacency. Each excursion is a new “game” whose outcome depends on how you conduct yourself in the then and there. Be just as cautious the hundredth time as the first.

When enumerated in the above way—the list is paraphrased from my field notes—Ryan admitted that the advice sounded unremarkable, even outdated. He had begun shoplifting prior to the widespread popularization of the internet, and he pointed out that, these days, anyone could simply input “shoplifting + tips” into Google and retrieve millions of results. But, he insisted, the only two tips that would keep a thief safe heist after heist were the ones whose mastery required hands-on experience and understanding: the first and the last. Like any acquired skill, theft required practice, discretion, forethought, and (somewhat ironically) vigilance.

It’s like anything else you want to master. It takes practice. You can’t—you can’t just grab a leather jacket off a rack and waltz off your first time. You start small. Cough drops, Kit Kat bars, bagels. It can’t be taught; you learn how to do it by *doing* it.

Ryan had never intended to become a thief. He became a thief entirely by accident and then embraced the identity after the fact. He and his older brothers were raised by a single mother, who worked night shifts as a private security guard and later as a nursing assistant, and who rarely spent daylight hours at home. She was in Ryan’s words, “redoubtable, the best, a fucking superwoman.” As in many working-class families, his mother and older siblings (who were both nearly a decade older than him) had invested in him their own dashed ambitions of higher education and social mobility. When he was ten, his brothers—Mike, who was twenty, and Leo,
who was nineteen—decided to rent a place together, and Ryan began to divide his time between
his mother’s and his brothers’ homes.

We were fuckin gods among men. We did anything we wanted. One time I said, ‘Mike! I’m goin out.’ And
he fuckin looked at me like I was nuts and he went, ‘I don’t fucking care!’ ((laughs)) … Leo was—Leo
would kick my ass if I slept in. ‘Go to fuckin school, you asshole!’ They wanted me to be a doctor or some
shit.

… Mike worked weird shifts. It was like, one day he’s lifting weights all day and then I don’t see him for
two days, then he’s back, and he sleeps for two days. ((laughs)) I loved that guy. He taught me everything.
Like, I don’t just mean like—not like ((mockingly)) how to shave, how to fight, how to change a tire. I
mean he fuckin taught me! Fuckin geometry! Fuckin Shakespeare! [Olivia: Fuckin bullshit!] ((laughs)) No!
No, he was a consummate badass. So intense. He’d go, ((gruffly)) ‘Come on, let’s fuck these equations up.’
And he’d fucking walk me through the problems.

… I was so hungry to be around him. Anything he said. He’d be home at like eleven (at night) and wake
me up and—you know, anyone else wakes me up and they’re gonna get—but he wakes me up, he’s got like
a pizza and Cokes, and he goes, ‘Hey man, let’s talk.’ … Oh, we’re having these epic conversations, he’s
like ((imitating a very deep voice)) ‘Get your head outta your ass. You don’t wanna end up like me. You
don’t wanna end up like dad. You sure as hell don’t wanna end up like Leo!’ ((laughs)) ‘Remember what I
told you. Stay in school! Find x!’ I thought that was so profound. [Olivia: Your whole family’s full of shit.]
Shut up.

His brothers’ exhortations kept him on the straight and narrow, at least for a while. At the age of
thirteen, however, he made a discovery that marked the start of a “personal decade of hell.” He
discovered that in addition to being attracted to women, he was attracted to men. Mike and
Leo—whom he idolized—were both virulently homophobic. He resolved to never come out.
Over the next few years, a stressed out and increasingly distant Ryan began experiencing a sort
of crisis of masculinity. He embarked upon an on-again, off-again project of cultivating a
menacing physical presence: he got into fights, lifted weights, verbally harassed women, and
began having components of a planned “sleeve tattoo” inked on his upper arm. He became
severely depressed and spent long hours lying in bed, nursing elaborate suicide fantasies. He
would abscond from his mother’s home after midnight screaming matches and smoke cigarettes
with his friends in “rich people’s” unmonitored and inadequately secured backyards. And his
mind was racing with worry about “what a fucking disappointment I was.”

During one of his nocturnal outings, he entered a convenience store to purchase a
chocolate bar. The clerk was preoccupied with another group of customers and made no
indication that he had any interest in ringing up Ryan’s purchase. Impatient, Ryan left; once
outside, he realized that he had forgotten to reshave the chocolate bar.

I was like, ‘Okay bitch, I’m just leave.’ And I go out, and like three blocks later, I’m like—I reach into my
pocket ((imitates discovering the bar of chocolate)) and I go ((laughing)) Shit! I’m a fucking thief! I ran.
That was the first time.

… I had never done anything illegal. I had not done weed. [Olivia, referring to his excursions onto private
residential property: Uh, trespassing?] Actually no no no no, it’s not the same thing. When you walk—
when you walk out with something you have not paid for, it is not supposed to be: nothing happens. You always think: something’s supposed to go off, an alarm. Or someone steps out and they kick your ass. When nothing happens, it’s—it—you don’t want to keep doing it, but—((inhales sharply)) once you realize you can ((exhalles))—once you cross the line, you can’t stop. You’re always gonna be thinking, ‘Fuck you, I don’t have to pay for this’ or ‘Let’s see how I can pull this one off.’ All the time. Because you know you can do it, because you’ve done it. It hits you: the law is just words. And you think you’re the shit.

… It’s like that Bon Jovi song, the—the Billy the Kid song. [Eugenia: The what song?] [Olivia: Oh, Blaze of Glory] Yeah yeah, Blaze of Glory. Go YouTube it, seriously.

The incident whetted an appetite that Ryan never knew he had. He soon began shoplifting with enthusiasm, targeting independent dollar stores and corporate retail giants with equal frequency. He was good at it, and it provided him with an outlet for his accumulating angst. But, eventually, he discovered that he could no longer go anywhere at all without stealing. No matter where he went—grocery stores, pharmacies, his friends’ homes, his teachers’ offices, the fast food establishment at which he worked, public libraries, outdoor markets, government buildings—he felt compelled to covertly pocket something. Even after swearing off the habit, which he did on a daily basis, even after reminding himself over and over that the risks were not worth the rush, he continued. The habit was no longer within his control. “I’d go into a trance,” he said. “I’d be like, ‘Okay, no more. That’s it!’ And then I’d go and do it anyway—and I always got away.”

His inability to master his compulsions terrified him. However, the situation was not without its merits. At the height of his addiction, Ryan realized that he felt almost totally emancipated from his brothers’ moral gaze, which for so long had prevailed upon him from afar.

I was like, ‘Fuck it. I’m a dead in a couple years anyway. You think you can judge me? You don’t even know me. You don’t know who I am. I’m a madman. I’m an outlaw.’

* * *

As we saw in the previous chapter, a powerful notion animating recent news coverage of the national “mental health crisis” is that psychiatric disorders disable sufferers’ productive capacities, thereby draining Canada of $51 billion annually. Within this ideological framework, the experiences that Ryan, Ivy, and Melinda describe indeed seem suggestive of recalcitrant psychopathologies that are masking their full labour potential. Melinda’s imaginary friends urge her to drop out of school and she complies, thereby costing the nation a high school graduate; Ivy’s preoccupation with invisible filth prevents her from maintaining her GPA and developing her musical abilities; and Ryan’s shoplifting addiction not only diverts his attentions from work and school, it contributes to $3 billion worth of lost retail sales per year (Powell 2011). When viewed through the Kirby Report’s reductive lens, the impressive stealth, forethought, creativity,
and risk management techniques that each deploys can be understood only as forms of
delinquency or irrationality (“delusions,” “obsessive compulsions,” “depression,”
“kleptomania”) for they are not being deployed in service of career advancement, scholarly
achievement, the national GDP, or the fortification of culturally sanctioned skills and networks.
In other words, it is not psychological abnormalcy in and of itself that transforms Ryan, Ivy, and
Melinda into legitimate objects of medical intervention under the new “national mental health
strategy” (SSC 2006: 429); it is the fact that they are misdirecting their time, talents, and mental
energies.

When viewed through a less economistic lens, however, it is clear that their respective
“mental illness” experiences enabled them to digest the casual assaults on their identity that were
so intimately a part of their lives, and provided much-needed alternative scripts for
understanding and processing their isolation, alienation and humiliation. By christening himself a
“madman” and “outlaw,” for example, Ryan transformed his addiction to a misdemeanour that
some criminologists consider stereotypically feminine (Caputo and King 2011) into a celebration
of insurrectionary masculinity. The song to which he compared his crime spree—Jon Bon Jovi’s
1990 power ballad Blaze of Glory—is narrated from the perspective of a murderer on the lam in
the Wild West who foresees himself dying “like a man… shot down in a blaze of glory.” The
narrator exults in his amoral itinerancy, repeatedly taunting his pursuers with the defiant
affirmation that he is irredeemable:

Wake up in the morning / And I raise my weary head /
Got an old coat for a pillow / And the earth was last night’s bed.
I don’t know where I’m goin’ / Only God knows where I’ve been /
I’m a devil on the run! / A six-gun lover! / A candle in the wind.

When you’re brought into this world / They say you’re born in sin /
Well, at least they gave me somethin’ / I didn’t have to steal or have to win.
Well, they tell me that I’m wanted / Yeah, I’m a wanted man! /
I’m a colt in your stable! / I’m what Cain was to Abel! / Mister, catch me if you can.

... You ask about my conscience / And I offer you my soul /
You ask if I’ll grow to be a wise man / Well, I ask if I’ll grow old.
You ask me if I’ve known love / And what it’s like to sing songs in the rain /
Well, I’ve seen love come! / I’ve seen it shot down! / I’ve seen it die in vain!

(Bon Jovi 1990)

Michael Kimmel has written that, “As a collection of dos and don’ts,” male gender norms
constitute “a recipe for despair” (2004: 525). As some ethnographers have noted (Anderson
1999, Bourgois 2003), the impossibility of satisfying certain standards of masculinity without
compromising others can lead men to destroy themselves and those around them by repeatedly
trying and failing to live up to a hegemonic illusion: that of the autonomous male agent who is
simultaneously tough, responsible, honourable, chivalrous, courageous, subversive, authoritative,
athletic, and intellectual, all in just the right proportions, and in a way that radiates absolute
confidence, authenticity, and undiminished “street cred.” By seeming to be the perfect masculine
role models—enthallingly complete in their mastery of both the physical and the mental—
Ryan’s brothers inadvertently constructed a prison for him, in which they could do no wrong.
Their homophobia was not a transgression against him; rather, it was his sexual identity that was
potentially a transgression against them. Ryan’s decision to bask in the revelation that he had
become an out-of-control “madman” is thus more usefully read as a form of resistance to the
symbolic violence of heteronormative masculinity than as any sort of surrender to the logic of
biopsychiatry.

Ryan’s conviction that he would be “dead in a couple years” is noteworthy in this
context, for the coherence of his narrative is not weakened by the fact that it is not oriented
around a valued long-term goal. One of the defining characteristics of the renegade-on-the-run
archetype is that the renegade inhabits a morally grey space, in which short-term survival is
prioritized over the long-term accumulation of resources and relationships. He fights, steals,
backstabs, and lucks his way from one day to the next, taking risks and making gambles whose
consequences—despite all his cunning—are uncertain. And it is precisely this existential
nihilism that imparts coherence upon his stories, which may seek to explain how he got this way
and why he’s fine with it without necessarily addressing where he hopes to go. While Ryan
acknowledged that his “trance”-like shoplifting habit eventually became an uncontrollable
impulse, its involuntariness was, in some ways, a welcome development, unmooring him from
the need to fulfill his family’s dreams of upward mobility (“I’m a dead in a couple years
anyway”) and impress his heterosexist brothers (“You think you can judge me? You don’t even
know me.”). Furthermore, by allowing him to conform to the parameters of a masculine
archetype with a long cultural history—the desperado, the amoral antihero—his crime spree may
have mitigated his subjective vulnerability to homophobic messages, a vital contribution in a
country where suicide rates for gay and bisexual youth are fourteen times higher than for their
heterosexual peers (Benibgui 2010).

The underlying point is not restricted to examinations of masculinity. Ivy’s and
Melinda’s stories also suggest that the phenomenological texture of a descent into madness is
more accurately represented as a type of journey than a type of illness. As we have seen, in
contrast with classic stereotypes equating “mental illness” with incompetence (Olstead 2002,
Reaume 2009), each of the three narrators displays fastidious levels of competence with their specific “coping mechanism.” This is a routine finding in the medical anthropological literature: Ivy’s regimen for protecting herself from invisible pollutants bears striking similarities to stories that anorexics and alcoholics often relate about rigorously scheduling their time and resources around a secret activity (Gooldin 2008, Gremillion 2003, Warin 2010, Murphy 1990: 68-73); and Melinda’s ability to negotiate the needs, activities, and opinions of multiple personalities brings to mind the fastidious “mental bookkeeping” exercised by effective spirit mediums in Mayotte and elsewhere, not to mention anthropologists’ critiques of cherished Western assumptions about the unity of consciousness (Lambek 2011: 724, 725; see also Boddy 1994, Keller 2002, Suri 2009). I do not wish to make too much of the intellectual work invested in these coping enterprises, as my aim is not to fetishize or lament the “lost labour” that it represents. However, I want to draw attention to the ways in which “alternative competencies” allow people who cannot escape their pain to instrumentalize it using alternative semiotic codes.

While Ivy was adamant that her green curtains of cleansing energy were not metaphoric of a need to cleanse herself of parental pressures—she insisted that they were literally visible to her—the logic that she developed around purity and impurity provided her with a safe, internally consistent idiom through which to express resistance. For the first time in her life, she had an equally pragmatic counterargument to her mother’s insistence on musical training: the flute was filthy. And for the first time, she was no longer powerless: she was “a pro.” While these revelations were unexpected, they were nonetheless gratifying and imbued her hourly rituals with moral coherence: short-term hygiene is a major organizing principle in our society (some would even argue that it is a modern obsession, see Hoy 1995, Lupton 2003, Mandziuk 2010), and there is nothing inherently irrational about suspending long-term goals to fortify oneself against omnipresent contaminants. What makes Ivy’s rituals “irrational” in the clinical eye is the fact that she is the only one who perceives the contaminants. By identifying her ability as “like, a gift and a curse,” she imparts an almost heroic logic upon it. Numerous mythological canons include cursed figures whose previsions of peril are chronically disbelieved: Cassandra of Troy, the wizard Merlin of Arthurian legend, various Biblical prophets. In this context, her reaction to her mother’s failure to comprehend her observation/warning “the house is so dirty” (“Good job! You think I’m gonna waste any more time on you?”), which could be seen as an OCD sufferer’s deluded outburst, instead begins to resemble the exasperation of an unappreciated seer.

What was most striking to me about Melinda’s story was the wholly unexotic origin she assigned to her flourishing imaginary universe, in which she was always already a hero. Many
children have what our society calls “imaginary friends,” and it is not unusual for young people to be “raised by the television” in neoliberalizing societies that require parental caregivers to accommodate ever-lengthier workdays (Arnett 2000: 282; Bezanson 2010). As the online “fan fiction” phenomenon demonstrates, it is not even unusual for adult enthusiasts of fictional franchises to devote hundreds of hours to inserting themselves into their favourite television characters’ “universes” by innovating new plotlines and writing original stories and teleplays (Black 2008, Chander and Sunder 2007). And so, when Melinda abruptly terminated her story just prior to what I had anticipated would be its climax, I was confused and troubled. I was expecting an account, after a year of eliciting such accounts, of a frustrating and frightening interaction with an institutional actor in the mental health system, and perhaps some reflections on how psychomedical terminologies could not capture the chronic sense of dislocation she had acquired from a nomadic childhood. Indeed, Melinda’s tale bears striking resemblances to a narrative I encountered during my perusals of the sociological literature on psychiatric survivorship/consumerism many months later, which concluded with precisely the sort of evaluative coda that I had raptly anticipated during our coffeehouse chat:

One woman had held a responsible position for several years and was doing extremely well. She came to trust her sympathetic doctor enough to reveal some of the unusual (and personally highly-valued) beliefs she continued to hold even while taking the medications that allowed her to keep her job… The doctor immediately changed her diagnosis from “bipolar disorder” (mood disorder alone) to “schizoaffective” (a combination of thought and mood disorder) since she was displaying “psychotic thinking.” She was hurt and angry about this dehumanizing experience: “I was still the same person, everything about me was the same but I had told him my inner thoughts. I trusted him. I should have known better” (Morrison 2005: 115; emphasis mine).

Melinda’s declination to complete her narrative (“Forget it, I’m crazy”) caused me to wonder if I had unwittingly reacted in a discouraging manner. To encourage her to continue, I tried various strategies: I assured her that I did not think of her as “crazy,” and that I frequently thought of myself as “crazy.” I told her that anthropologists had a long tradition of seeking to understanding alternative ways-of-being and that there was nothing pathological about her. But she insisted that the story was over. She politely thanked me for listening, we parted ways, and I spent the night mentally revisiting every moment of our interaction, worrying about what heinous thing it was that I had said.

Several weeks later I learned from Olivia that Melinda had, in fact, produced a complete story about her encounter with psychiatry and what it had done to her. Her career counsellor’s instinctive alarm at her nonchalant admission that she “heard voices” and had “people in her head” constituted, in her eyes, incontrovertible evidence she inhabited an unsafe world. It was all the proof she needed that, courtesy of the breathtaking level of credibility that psychiatric
reasoning enjoys in our society, she would never really be able to speak freely about perceptions that to her were as normal and familiar as the sun in the sky. The point at which she had terminated her story (“I realized—it really hit me—that I was in real danger”) exposed the moral significance of her being referred to a mental health nurse. In one brief sweep, Melinda politicized, critiqued, and put the lie to the mainstream conception of mental health ideology as something that liberates people of unwanted demons. The fact that I failed to recognize that this was the story’s organic conclusion (“What happened next?”) may have suggested to her that I didn’t quite “get” it.

Critical disability theorists often point out that the adjective “crazy” is an alienating term that reinforces the view that the minds of the mentally ill are unknowable (Devaney 2008: 124, Fitch 2002, Perring 2009). I want to suggest that it has another use, at least inasmuch as “interactional experiences are incorporated into memory to form commonsense expectations and reactions” (McElhinny 1995: 227). In interactional situations where a person has become habituated into being treated with disbelief, misunderstanding, or condescension, phrases like “Forget it, I’m crazy” can be placeholders for “Forget it, there’s too much to explain.” When a person pleads insanity in order to forestall a line of questioning that experience has taught her will be exhausting, exasperating, and emotionally costly, she signals her resistance to having to unendingly justify the way she is. And to reassure such a person that she is “not crazy,” as I instinctively did, may be to unwittingly signal that there is something wrong with being “crazy”—that there is something wrong with being the only one who knows one’s own mind.

3. **Iatrogenesis: Derailed Identities, Disarrayed Bodies**

3.1 **Losing One’s Self to Psychiatry**

3.1.1 **“Like Searching for Darkness with a Flashlight.”**

I have mentioned that hopelessness and directionlessness can impart coherence upon certain kinds of life narratives. Indeed, it became clear to me during my fieldwork that the idea of being uniquely undecipherable, unpredictable, unrepentant, recidivous—or simply “crazy”—had deep existential appeal to some of my informants, at least during their initial forays into madness. I do not claim that this was a universal theme, but it was a noteworthy one: of twenty-six interviewees who identified as psychiatric survivors and shared histories of madness and psychiatrization with me, fifteen noted that self-destructive impulses did not diminish but, in fact, enhanced their feelings of self-worth during challenging events and encounters. The following quotations highlight the centrality of this move in interviewees’ stories:
I had no moral compass. I’d have done *anything*, and I did. It was just, ‘Let’s see how utterly, exotically broken I can get.’ Because—it’s hard to explain, but—if you haven’t put a chair through a window or—or—you know?—you and I cannot have a conversation. Even if you’re eighty-nine, you are an infant to me. You know nothing; you are not my equal. (MacDaniel, referring to the lowest point of his life)

Lots of guys call themselves fucked up to get attention. I actually *was* fucked up. It was [a point of] pride for me, that I was not a poseur. (Renée, referring to the first time she successfully regurgitated a meal)

She said, ‘We’re a lot alike.’ I got mad. ‘We’re nothing alike. Get the hell away from me.’ You know, she’s got a job, friends, dreams, a future—everything that makes you anything. And I just couldn’t—I thought, ‘What have you suffered? Who are you? Cause me? I’m a nightmare. I—I’m mayhem. You don’t deserve to talk to me.’ (Magda, referring to a conversation with a friend who had tried to reach out to her during her anorexic years)

There are times you feel as though you’re sliding back and it sounds a bit demented but it’s like running into an old friend you used to get high with. They say you’re going nuts, but you know you’re just going home. (Jared, referring to his depression)

Thing is, you have to be really wholesome to get into medical school, all the volunteer work and the 90s, the references. … It’s like searching for darkness with a flashlight. They couldn’t know thing one about me. (Nathan, referring to psychiatrists)

These defiant enunciations become less mysterious when we set aside neoliberal health/illness binaries that implicitly define “mental illness” as the condition of having problematic desires and priorities, and when we remember that self-destructivity can feel liberating during times of unendurable social pressure (e.g. Ryan). In addition, the air of superiority conveyed in these excerpts—of enhanced wisdom in comparison to people who “haven’t put a chair through a window” (MacDaniel), are inadequately “fucked up” (Renée), are sociable and gainfully employed (Magda) or prestigiously credentialed (Nathan)—demonstrates that “madness” does not have to be *romanticized* to be seen as something worthwhile, edifying, or affirmative of personal uniqueness. Jared’s formulation, in which depression becomes a “friend,” is particularly revealing here, for he accepts the division between self and illness that structures mass media discourses (chapter 4), but without transforming the illness into a villainized presence. Rather, Jared’s depression resembles a chance encounter with an “old friend you used to get high with,” whose reckless priorities are nonetheless a reminder of “home.”

As suggested in the foregoing pages, the notion—so heavily advertised in our medicalized society—that pain and madness *only* defile and derange is belied by the extensive work that people can and do put into discovering value in stigma and refashioning their identities to accommodate rather than deny inescapable suffering. There is of course a socio-political and economic context to these narratives, in which increasingly competitive pressures (Ivy, Ryan), prescriptive gender norms (Ashley, Ivy, Olivia, Ryan), constant geographic relocations (Melinda), and a backdrop of financial anxiety effect invisible violence upon ordinary people
trying to survive. Nonetheless, we should be cautious about accounting for destructive acts and impulses by appealing to strictly materialist rationales: although such counterarguments can help to destabilize overly biomedical logics (e.g. identifying relationships between poverty and petty crime, or marketable body shapes and rates of anorexia), they can also elide the subtle philosophical inducements that some see in their alienation and exile. As Holly Wardlow (2006) has noted, to treat individuals’ actions as axiomatic outcomes of structural forces is to erase their personal agency—their capacity and right to prefer to be “wayward” when understanding is absent and acceptance seems impossible.

We cannot forget, of course, that the transgressive meanings that people invest in their madness are rarely if ever intelligible to those around them, from whom they are at constant risk of psychiatrization: friends, kin, neighbours, employers, teachers, social workers, health professionals. I do not want to either romanticize or relativize the loneliness of “mental illness,” which does not have to be biogenetic or blood-borne to feel devastating and to have negative impacts on a person’s life. The costs of self-destructivity are high; no matter how vindicating it can feel to be “a madman,” “an outlaw,” or “a nightmare,” it is hard to live on a downward spiral. And, as the news media increasingly remind us, to fail for whatever reason to apply one’s fullest enthusiasms to respectable work that earns a paycheque is to invite derision, privation, scrutiny, and alarm. I now turn to the question of what role the “mental healthcare” system can often play in such a context.

3.1.2 First, Do No Harm?

Olivia. In the weeks following Greg’s departure, Olivia felt a peace that she had not known in years. It was, she said, “actually, a little too peaceful.” While she would later read that other ECT survivors had experienced similar after-effects from the procedure—inappropriate feelings of euphoria, muted emotions, difficulty retaining new information—she at first thought nothing of it. She returned to her job as a mailroom assistant and tried to reassemble her life by applying for a promotion. Her supervisor told her bluntly that her job performance had declined unacceptably since her hospitalization and that she seemed to have developed “an attitude.” “I had no idea what she meant,” Olivia said. But one evening, about three months after her release, she was watching a late-night talk show and happened to glance over into her bedroom window.

I was laughing—it was just something dumb on Letterman—and I turned and saw my face in the glass. You know, cause it was dark out; the glass turns into a mirror. And I was not laughing at all. I mean, I was laughing—it felt like laughing—but it wasn’t correct, I wasn’t emoting. My face was totally flat. Like, no expression, no inflection, nothing.
… I have actually had to retrain myself in this regard. When I feel like I’m smiling, I have to check. I carry a compact just so I can peek, to see: am I really smiling or what?

Not longer after this incident, Olivia was “restructured” out of the company and found herself in the precarious circumstance of having a “glitchy brain,” no income, and a network of friends whom she no longer trusted and who, at any rate, seemed to no longer feel comfortable around her. Unable to make rent, she wound up temporarily homeless. As she told me by email,

…the mythology surrounding homelessness is brutal. you guys [social scientists] deceive yourselves about how vulnerable we [people with homes] are b/c you associate homelessness with absence of money. i had money, i put my important stuff into storage when it hit me i was running out of time. my problem was i couldn’t get my head sorted out enough to go apartment-hunting. i was messed up from the shock [electroshock]. there’s no magic safety net, when the month ends you’re homeless. my plan was to find another place w/n 2, 3 days and just rough it, you know, use the public washrooms in malls and stuff.

… when you live on the street, you are living under permanent siege, it occupies 98% of your consciousness. when you guys talk about getting homeless of the street what you don’t understand is it’s not a matter of no opportunities, it’s a matter of no headspace. when your only goal is making it from minute to minute, you don’t plan for the FUTURE, you plan for the HOUR. it is unsafe in shelters and wards, people prefer the streets to being in continuous threat of assault, but there comes a time when assault looks better than exhaustion. you know how if you don’t get enough sleep it fucks you up? imagine never ever getting enough sleep. the homeless aren’t mentally ill, they’re spent from being unsafe and living in a state of total war. they are totally outside of civilian life. anyone who thinks they can do it is crazy.

After five days, a desperate Olivia checked herself back into the same mental health facility she had once been so relieved to escape.

They saw that I’d been there before and had all these diagnoses, so the first question they had was, ‘Have you been taking your meds?’ Well, no, of course not. So they were all ((imitating scribbling in a pad)), ‘Not med compliant.’ And the shrink—it was a new guy—the shrink went, ‘Just like a diabetic cannot live without her insulin, you will never be able to live without your medication. Stay on your meds, or we are going to be seeing a lot of each other.’ I was like, ‘Listen, fuckneck! I am here because I checked myself in. I don’t have another place to go.’ I don’t need some asshole MD to mansplain my own life to me.

… My life became disorders and bad food. They really broke me down. Bipolar, Borderline, Anxiety, Depression. Drugs, potatoes, drugs, drugs, potatoes. I truly went insane. … I think I might have stopped talking. I guess that’s what they call ‘getting better.’

* * *

Olivia’s story is instructive in a number of respects. It was ultimately true that the availability of mental healthcare services furnished her with shelter and sustenance during a period of particular marginality and vulnerability. Taken in isolation, this observation would seem to vindicate received wisdom about the saving graces of psychiatric inpatient wards for urban indigents. However, we must also recall that Olivia ended up on the street at least partly because of her

84 The verb “mansplain” is a portmanteau of the words “man” and “explain.” Usage of this verb has become popular in feminist networks over the past few years. It characterizes interactions in which men provide women with unsolicited, condescending and sometimes inaccurate explanations in the total confidence that their input will be received with interest and gratitude.
initial encounter with psychiatry, during which physical, chemical and electrical procedures were “prescribed” with lasting somatic consequences. To understand this claim, some context is required. Due to a lack of public awareness about psychopharmaceutical iatrogenesis, it has been easy for stereotypes about “drooling mental patients” who need medication in order to behave normally to proliferate in the mass media, thus reinforcing such stereotypes in a cyclical fashion. A case in point is that of mathematician John Nash, who, in real life, permanently ceased taking his antipsychotic medications twenty-four years prior to winning his Nobel Prize, because, according to his biographer, “such drugs, in a high percentage of cases, produce horrible, persistent symptoms like tardive dyskinesia—stiffening of head and neck muscles and involuntary movements, including of the tongue—and a mental fog, all of which would have made his gentle reentry into the world of mathematics a near impossibility” (Nasar 1998: 353, quoted in Morrison 2005: 94-95). However, in the 2001 film A Beautiful Mind, Nash is portrayed as having to resume taking medications in order to regain his professional standing and become a Nobel laureate. Given the film’s hopeful message, this reversal may seem inconsequential; the simplifying plot change is, after all, a defining feature of the Hollywood biopic. Because mass media consumers are already conditioned to see the “mentally ill” as Other, and to see timely biopharmaceutical treatment as restorative, this plot change even makes perfect sense. However, it is vital to also consider what kinds of experiences get masked under these circumstances:

In April 2005, a public hearing was held at Toronto City Hall, where past and present recipients of psychiatric medications and electroconvulsive therapy testified over four days. One testifier (“Joe”), who had been medicated over many years for obsessive compulsive disorder, manic depression, and anxiety disorder, described his medicated state as an “induced” “bog of nightmare,” stating that

The reason I wanted to come off the drugs was because I couldn’t feel anything. It wasn’t helping anything. It made life easy for everyone else because I was docile. I was like, when you look into the eye of a cow, that was what I was like, or a broken horse—nice and tame, right? But meanwhile, I’m suffering, I’m dying inside. I’m lashing out at people and I’m not even aware of it because I’m so drugged up. I’m not allowed to feel grief. I’m not allowed to feel anything (Coalition Against Psychiatric Assault 2005: 92).

Another testifier, describing her experience on tricyclic antidepressants, revealed that

---

85 Tardive dyskinesia, known as “TD” in the psychiatric survivor community, is a neurological disorder that can result from antipsychotic and tricyclic antidepressant usage (Trimble and George 2010). It incurs repetitive tremors in the facial muscles, limbs, and torso, thereby causing involuntary lip-smacking, chewing, grimacing, head-bobbing, writhing, finger-flexing, and foot-tapping. These symptoms are sometimes mistaken for effects of illness rather than effects of medications (Aia et al. 2011, Koshikawa et al. 2011: 4-6; see also Estroff 1992).
I went from a really shy individual to a very, I don’t know how you’d say it, almost obnoxious person. It was like I was superman, had no fears of anyone despite my size which is quite small. … I ripped my whole house apart for no apparent reason. I just woke up one day, got up, went to my living room and just started throwing all the books from the shelves, I messed up the entire living room and I couldn’t even explain why I did it. I had this urge inside of me that just said rip up the living room and I did it. And that’s what drove a lot of my behaviour too. I would just snap at people for no apparent reason and I could never really explain why I was doing it until I kind of put two and two together and realized that the medication was really causing me to be very violent. I can tell you that—I know for a fact that it was doing this because once I got off the medication, I went back to my normal self—shy, generally reserved. I have a checked tendency to speak my mind about a lot of issues, but a lot different than how I was when I was on medication (Coalition Against Psychiatric Assault 2005: 105).86

In the above excerpts, medications are depicted as forces that seize control of patients’ bodies and wills, leading them to behave in ways that their “unaltered” selves would find objectionable (e.g. “lashing out at people and I’m not even aware of it,” “the medication was really causing me to be very violent”). The first speaker asserts that his treatment transformed him into a volatile figure, alternately “docile” and “lashing out,” while his authentic self was “suffering, dying inside.” The second speaker draws a clear line between the “shy, generally reserved” baseline that she recognizes as her personal norm, and the “obnoxious,” erratic person that destroyed her own living room. My focus here is not on the empirical substance of their perceptions, but the fact that they perceived their “treatments” as sources of trauma and torment, rather than healing.

“Joe’s” contention that his drugs successfully rendered him “docile,” “nice and tame,” must be unpacked in light of this observation. Does the inducement of a compliant demeanour necessarily signal the restoration of a patient’s authentic, “mentally healthy” personality? It may be helpful here to consider some testimonials from survivors of electroconvulsive therapy, a biopsychiatric technique that was originally invented to induce docility (see chapter 3). While memory loss from ECT tends to be portrayed in the clinical literature as an inadvertent, occasional, and temporary side effect (e.g. Goodman et al. 1999, Rosedale 2011, Ottosson and Odeberg 2012), some healthcare professionals have acknowledged that memory erasure is sometimes, unbeknownst to its subjects, the primary therapeutic mechanism. As Burstow (2006a: 377) documents, “at a review board hearing that I attended as an expert witness, the psychiatrist who was seeking permission to force electroshock on a woman who was not eating took the patient’s lawyer aside and told the lawyer that electroshock would solve the problem, for after shock, the woman would not remember why she was not eating and so would likely resume

86 This testifier continues her story thus: “I guess I’m bringing this up right now because of a lot of what’s been going on in, a lot of what we’ve been hearing in the media the last little while in terms of school shootings and murders of parents by their children—and it comes out later were on anti-depressants of one sort or another. I can tell you that I very much relate to some of this behaviour because I can tell you that when I was on the medication and if I had a gun at my disposal, it could have gotten pretty nasty” (Coalition Against Psychiatric Assault 2005: 105). The significance of this claim, and others like it, will be revisited in chapter 7.
eating” (see Breggin 1994 for similar examples). However, in the following testimonies to the Toronto Board of Health (quoted in Burstow 2006a) and the U.S. Food and Drug Administration (quoted in Andre 2009), psychiatric treatment is once again depicted not as a healing intervention that restores and reconstitutes patients’ true abilities and ambitions, but as something that ruins them:

As anybody knows, the kind of creative writing that you do… depends very strongly on what you are made up of, what your past memories are, your past relationships, how you deal with other people, how others deal with other people—all these things. I can’t write anymore… Since the shock treatment, I’m missing between eight and fifteen years of memory and skills; and this includes most of my education. I was a trained classical pianist… Well, the piano’s in my house, but… it just sits there. I don’t have that kind of ability any longer (Connie Neil, quoted in Burstow 2006a: 380; emphases mine).

The 2 years of college I had before the shocks was gone. All I had was a vague memory of my art professor when I looked at the painting I’d done hanging on my wall. So the shock doctors were not only barbaric—they were thieves, robbing me of the one thing in life that brought me the most satisfaction. From day 1 I had dreamed and fantasized of being a teacher… If it weren’t for the ECTs I’d have my master’s or PhD and still be teaching. ECTs raped and robbed my brain. I’ll go to my grave with this—the worst thing that ever happened to be in my whole life (Betty Scoleri, quoted in Andre 2009: 307; emphases mine).

Before ECT, I studied math up through calculus. After ECT, I can just barely make change in a store. ECT gives a person a different brain from the one a person had. One never feels sure about this strange new head. Some things come back. A great deal of memory never returns. And one cannot retain new information, so one’s future is DEAD (June Bassett, quoted in Andre 2009: 313; capitalization in original, boldfaced emphases mine).

I found myself wondering such things as: What is that thing (the machine I later recognized as my vacuum cleaner), and what is it for? I wonder if there’s any way I can get my floor clean? Is cleaning floors something that normal people do, or am I being strange to want to clean my floor? Who lives in that house across the street? Did I used to know who lives there? Am I the kind of person who would have known who lives there? What kind of person am I anyway? What did I used to believe, and would I believe the same things now? At least a couple of times every day, I found myself screaming… uncontrollably. When there was verbal content to my screams, it consisted of such things as: “What have they done to me??” “They’ve destroyed me!” “My self is gone!” … faced with the choice today, I would unhesitatingly prefer death to ECT (Karen Rian, quoted in Andre 2009: 314-315; italics in original; boldfaced emphases mine).

The metaphors deployed in these testimonies are particularly instructive when we recall that, in mainline discourses, it is “mental illness” that tends to be assigned predatory and criminal characteristics (chapter 4). In a jarring reversal of this trope, ECT recipients liken psychiatric practices and practitioners to thieves, robbers, rapists, and destructive agents, underscoring the inseparability of memories (and their loss) and selfhood (and its loss)—not only in terms of learned information, but technical skills, relational habits, and basic sociocultural knowledge. It

Although not all ECT recipients complain of memory loss, one ECT survivor has pointed out that “we tend to underestimate the extent of our amnesia because you can’t know something is missing from your memory until someone else tells you about it or you accidentally discover it” (Andre 2009: 244).
is also worth noting that, despite claims about the molecular specificity of post-1980s biopsychiatry, ECT remains widely prescribed well into the 21st century (Sackheim et al. 2007).

Olivia, of course, cannot empirically prove that her diminished state (e.g. inability to smile reflexively, “glitchy brain,” worsened job performance) was a direct consequence of her ECT. She was nonetheless adamant that the disorientation she experienced following her electroconvulsive and biopharmaceutical treatments was the determining factor in her erratic behaviour, her job termination, and her subsequent downward spiral. Even if causality cannot be ascertained here, the fact that Olivia has come to see and speak of her psychiatrization as a series of debilitative, rather than rehabilitative, life events is in itself revealing. As another of my interviewees (Vanessa, see below) put it, alluding to the psychiatric survivor movement’s chosen name, “No one should have to ‘survive’ going to a doctor.” Indeed, what does it mean that so many patients perceive mental health interventions as forms of torture rather than therapy? Or that their point of view is so rarely publicized in the mainstream?

By checking herself into the facility as a desperate gambit to get off the streets, Olivia was displaying a level of concern for self that the clinical literature idealizes: she identified a material need, knew exactly where she could have it fulfilled, and agentively pursued this goal without delay. The horrifying denouement to this series of events, in which she is obliged by her custodians to consume a steady diet of “drugs and potatoes” that enfeeble her verbal faculties brings to mind Shumka and Benoit’s (2007) insight that the Canadian healthcare system’s focus on emergency services comes at the expense of preventative ones. That is, when people “fall through the cracks” and wind up homeless, they have no recourse outside the psychiatric system (e.g. housing programs, OHIP coverage for non-biomedical goods and services, diverse and flexible employment options, affordable nutritional options), and thus no alternative to forms of “treatment” that—to them—end up being torturous.

Social science researchers sometimes critique psychiatrists for focusing more on the form than on the content of lived experience and, thus, becoming preoccupied with arresting “symptoms” against individuals’ wishes (e.g. tranquilizing auditory hallucinations that are meaningful to patients, Smith 2007, Crossley 2004; or physically barring self-injurers from modes of action that are therapeutic to them, Cresswell 2004; see also Desjarlais 1997, Littlewood 2002, Suri 2009). However, as Olivia points out, we are guilty of similar errors. Just as Olivia’s clinician blamed her hospitalization on her failure to comply with medical advice, social scientists often blame the social safety net’s notorious failures on the psychiatric system’s failure to aggressively pursue and absorb those who “fall through the cracks” (Bonin et al. 2009:
For many psychiatric survivors, being caught in psychiatry’s “safety net” is indeed a crucial turning point in their lives—but not always for the better. Their grievances are encapsulated in Irit Shimrat’s (1997: 158) contention that “[w]ith drugs, electroshock, intimidation, coercion, humiliation—and, of course, with the best of intentions—the mental health system has created a subclass of sick, unemployable, unhappy people—chronic mental patients.”

What is key here is a striking mismatch between the image of psychiatry as a set of practices that primarily heal sick people (mitigated by occasional medical misadventures) and psychiatry as a set of practices that primarily sicken healthy people (mitigated by occasional success stories). I do not claim to be able to arbitrate between these two sets of truth claims, and I am not advocating the curtailment of mental health services upon which many people in fact rely. But I feel I should note: although I entered the field equipped with sundry anthropological critiques of psychiatry, I was unprepared for the torrent of stories that people told of being ensnared and annihilated by an initial, innocent psychiatric encounter. Again and again, speakers used the same vehement phrases to describe their relationship with the mental health system: “Once you get sucked in, you never get back out,” “I wasn’t sick when I got in, but I sure as hell was when I got out,” “There is nothing left of the person I used to be,” and, most revealingly, “Young people are particularly at risk of psychiatry” (a construction that the news media typically reserves for disorders, as in “Young people are particularly at risk of depression”).

These productions are useful empirical illustrations of Margaret Lock’s (2001: 483) observation that “We cannot function without concepts and taxonomies, but when applied as though universally objective, they enable the proliferation of scientific truth claims that often fit poorly with lived experience.” To underscore this point, I provide here a series of firsthand accounts that tend to be systematically excluded from mainstream narratives denying the authenticity of “mentally ill” selves. In each case, bolded typeface signifies passages to which I wish to draw attention.

- Nathan, a close friend of Ryan’s and Olivia’s, who suffered from what he jokingly called “debilitating dissatisfaction and a gruesome personality,” related the following experience to me by email:

  It’s just alchemy. All a shrink does is try different stuff to see what does what. A pinch of this, a dash of that. They do it backwards. I saw a guy once who diagnosed me that way. He had me on five different drugs, one at a time, to see how I’d react. I know sometimes they say it’s like a doctor deducing what bacteria’s in an infection by experimenting with different penicillin, but it is not the same. Every month, I was a brand new person; I was crying, I was laughing, I was screaming, I thought aliens were living...
in my brain, and this guy’s just turning the knobs and dials, going “Mm hmm, fascinating, I see.” Paxil doesn’t work, so let’s try Effexor. How about Risperdal? Maybe add a touch of Xanax. It’s sort of a twist of irony because that’s how I fired him: the Xanax gave me rage. I felt like it was either him or me; I was this close to killing one of us and I thought, well, shit. Normally I’m more suicidal than homicidal; this is bad; I’d better get out of here.

… I went back to my old high school and found a counsellor I used to see, and he actually really helped me sort things out. He said, “Have you seen a psychiatrist?” I laughed like a hyena. “Uh, why do you think I’m so fucked up?!”

- Leigh, who considered her experience too “trifling” to qualify her as a bona fide psychiatric survivor, related a similarly disturbing account:

  I was started on antidepressants for insomnia after my niece’s funeral. I worked in reception and my boss sort of warned me, ‘Look, this can’t go on’—I guess I was crying quite a bit at that time. So, I paid my GP a visit and she wrote me a scrip [prescription] for SSRIs and also benzodiazepines [anxiolytics, which are supposed to have sedative effects] at quite a high dosage. … I started going a bit bonkers. I couldn’t sleep but I was drowsy all the time. There were nights when I got up at three, four A.M. just to pace—to feel the floor beneath me—because I thought any second it would crumble away like a biscuit. … My heart raced. If I was behind the wheel, I had to hold myself back, consciously, from jerking over across the yellow line. I felt possessed. It wasn’t me.

  … When I saw her again [her GP], she just made out the same scrips and said, very smug. ‘You have to take your medication every day.’ … So one day an old friend told me basically, ‘Look, go see mine [her doctor]. She’s terrific, she’ll figure it out.’ She [the new doctor] took one look at me and said, ‘Get off those drugs.’ And it was ((snaps her fingers)) a fog lifted.⁸⁸ I could sleep again, I wasn’t shivering or sweating, convulsing. I felt like myself again. … For as long as I live, I will never never never forgive that woman for stealing those two years from me.

- Magda, whose father had once assaulted and almost asphyxiated her in an effort to get her to eat, had been hospitalized twice for anorexia and released each time with additional diagnoses and prescriptions. She related the following experience:

  Psychiatry fucked me up royally. They put me on happy pills [antidepressants] and benzos [benzodiazepines] and I started having these berserk thoughts of, like, every kind of carnage … I couldn’t get these urges out of my brain… to stick a vacuum cleaner hose over my eye socket and turn it on. Or to scratch my eyeballs out with sandpaper. I know—what the fuck, right? … It was just waves and waves of dread; I couldn’t stand being in my own skin. I don’t mean I was suicidal—that’s not what I mean. I don’t mind being suicidal; this was a totally different thing. I felt like—I wanted to rip the meat from my bones, I couldn’t stand wearing it, and if I had to die then okay.

  … Who the fuck is actually helped by these things? I really want to know, like what percentage of users. Cause once I got off the drugs, I chilled out. … They [her parents] would have killed me if they knew [that she had secretly weaned herself off of her medications]. They’d just, vppp ((points over her shoulder with her thumb in a swift motion)) back to the psych ward! … Believe me, I keep my secrets secret now. I’m not a puzzle, and I don’t want to be cured.

- Jared, who had once taken medication for clinical depression and who attended the Acceptance group, related:

⁸⁸ Quitting psychopharmaceuticals “cold turkey” does not always yield such positive results. I will discuss one particularly tragic example in chapter 7.
I felt like a shitty piece of merchandise. I got headaches and anxiety, which I never used to. My thinking slowed down. What else? I developed rashes, my pupils wouldn’t focus, I couldn’t write the way I used to—the words just weren’t available anymore. If anything, it amplified the depression, because at least before I knew the pain was me. … My doc was an asswipe. He switched me to Lexapro, which turned me into a zombie. I would sleep half the day and still be too wasted to go to class. You know what he said to me? He said, ‘Jared, you need to show more initiative. The drugs can’t do all the work.’ …

He said, ‘There can’t be any secrets between us. We’re a team.’ Here’s a thing they teach you in med school: keeping secrets is what recalcitrant patients do. [Eugenia: Recalcitrant—?] The ones who are too crazy to want to get well.

**• Deirdre,** Jared’s fiancée, who had been diagnosed with “Panic Disorder with Agoraphobia” and was an active user of psychiatric services, related the following by email:

There is this errant notion floating around that if you are undergoing a crisis and in need of care, you ought to book yourself into a ward. This is a fable; it is extremely damaging. Inpatient wards are no place for anyone in emotional crisis; they are in essence drunk tanks and little more.

… At intake, they make you turn over your wallet and shoes. You get used to being told what to do and when one hundred per cent of the time. **You take pills that make you convinced your brain is infested with worms.** You get used to being talked to like your two years old. You get used to chewing on slabs of canvas they call meat and trying to break it up with a plastic spork. You go to “therapy”, where the facilitators criticize you the whole hour: “Your [sic] so bright; why did you drop out of school? Your [sic] so creative; why did you quit your job? You get used to saying “I don’t know, I don’t know, I don’t know” because nothing else will make sense to them.

It’s not Clockwork Orange. If you play the game, you can get out. But you’ve not been given any new tools for facing the world; what you’ve got instead is an abject lesson in how much worse your life could be.

**• Vanessa,** who lost over twenty years of memory after a series of electroconvulsive and chemical interventions, shared a poignant essay with me by email, which I excerpt below. The underlining appears in the original.

I had insomnia. I had been prescribed a benzodiazepine. After my mother died I took more of the benzodiazepine. I shouldn’t have. I was sensitive to it and my sleep became worse. Doctors considered me to be depressed.

Antidepressants were prescribed. I took them because I was desperate to sleep. I developed akathisia—a motor restlessness syndrome seen in relation to antidepressants and antipsychotics. It manifests as mental unease and restless movement. The psychiatrists did not recognize akathisia. They diagnosed agitated depression and added more drugs. As **dozens** of drugs were added, the severity of the diagnoses escalated: major depression, psychosis, psychotic depression, dementia, vegetative depression, suicidal ideation, delusional ideation, paranoid ideation, etc, etc, etc. I was given sleeping pills three times a day to combat the agitation that the antidepressants and antipsychotics and benzodiazepines and sleeping pills were causing. **I was driven “mad.”** I was diagnosed with dementia. By this time anyone would have been depressed. And eventually I believed and agreed that I was indeed depressed. …

… I feel so sorry for the terrified woman [she is referring to herself here] who is lying on a gurney shaking from fear, from hyperthyroidism, from hypoglycaemia, from pharmaceutical drug withdrawal, and from akathisia…. She does not comprehend why she is being tortured in the name of medicine. Her body is rigid and her fists and teeth are clenched as electrodes are placed on her head and a tourniquet is tightened around one arm. The faces around her are matter of fact. They belong to efficient assembly-line workers, Then, as the IV anesthetic needle pierces her skin, a nauseating plunge to oblivion, perhaps to death. And yet she lived. She does not remember most of the bilateral shocks. She had 25 of them before she defied her tormentors and walked away. She remembers only a little of the last few times. Otherwise—nothing. She doesn’t even remember that she refused the procedure.
She doesn’t remember that her husband came every night for 75 nights in a row to bring her a home-cooked meal. Each evening when he arrived, she was surprised to see him. She didn’t remember that he had been there the previous night. … She doesn’t remember that every time he came, she asked him the same questions: “Where am I, what is happening, and why?” She will spend the rest of her life paying for someone else’s errors. Her husband will spend the rest of his life living with guilt and grief.

… I have a life of joyless striving… Most of my old friends are gone. I was too much for them and they, obviously, were not enough for me. I feel betrayed. They disappeared quickly when they saw me trembling and spasming, and muttering and howling. They didn’t even want to consider that my “behaviour” might have resulted from the dozens of pharmaceuticals that had been prescribed for me within a few months. Some came to see the curiosity I was when I was hospitalized. They are no longer interested in me. One “friend” even opined that the doctors had made me well. I am disgusted.

I will forever be seen by others through their “filter” of “mental illness.” Psychiatric labels stick. Those who tell me to “get over it” and “stop dwelling on it” are in fact asking me to forgive the unforgivable.

… The last time I looked, I was 40. Now I am 65 and the past 25 years are missing.

- Ryan, whose magnetic personality made conversations about any other subject both edifying and hilarious, would stiffen whenever the subject of his own hospitalization arose. I was never able to ascertain what specific sequence of events had led to his becoming an inpatient at an addictions clinic, nor exactly what had happened to him while there. When asked, he would gently discourage the line of inquiry (“Nothing much,” “It doesn’t really matter”) or downplay the significance of the experience (“They said I was nuts. Same shit as everyone else”). During a particularly animated debate with another Unhinged member, however, he was more direct:

  I am not a ‘psych survivor.’ I fucking can’t stand that term. The man I was did not survive his run-in with psychiatry. And if you did—what, am I supposed to feel sorry for you?

Olivia later told me that Ryan had “never really gotten over” the indignity of receiving a diagnostic label, which she did not reveal so as not to reinforce its epistemological legitimacy. Although he had never, as far as she knew, experienced the same visceral responses to somatic treatments that she and their friends had, she was emphatic that his trauma was no less real.

  There’s a line I read once. Devin Grayson, I think? ‘Identity is fragile. We cut it out of glass and pretend it’s cast iron.’ … You have to understand, he has never been a known quantity. How do you think it feels? To carry all this pain inside, things you don’t even understand yourself, and have some shitty little white-coat [physician or scientist in a laboratory coat] tell you, ‘Duh, I know all about your kind. I read all about you in class.’ You know? … Me, I was used to being a nothing. Him, I think not so much.

3.2 The Wisdom of Silence

While studying at Harvard University in the 1970s, David Oaks began “entering altered states that were sometimes delightful, sometimes painful, but that all had some validity to my life—just as dreams often do” (2001: para. 15). There were occasions when he felt that performers on television were speaking directly to him, or that spaceships were appearing in his living room, or
that God was communicating to him through his radio. “I learned a lot from those states of mind,” Oaks (2001: para. 15) has asserted. After his parents had him hospitalized, he received diagnoses of schizophrenia and major depression, and he was “told I would have to stay on psychiatric drugs the rest of my life” (Oaks 2001: para. 16). Oaks was subjected to several forced hospitalizations, during which

I experienced forced neuroleptics as torture. The harder I tried to think, the harder it was to think. The more I tried to move my body, the harder it was to move my body. … for me, it was like taking a wrecking ball to the cathedral of thoughts, feelings and experiences that defined me at that moment. It was incredibly intrusive. I could feel how the chemical affected my vision, my movements, my thoughts (Oaks 2001: para. 23).

In his senior year, Oaks contacted one of the earliest psychiatric liberationist groups—Boston’s Mental Patients Liberation Front—which eventually helped him to achieve his permanent release from forced treatment. During his final hospitalization, a Liberation Front activist dictated the text of a legal appeal over the telephone, which Oaks typed, printed, and presented to hospital authorities. When administrators contacted Oaks’s parents, they decided to support their son’s bid for freedom and did not request further commitment. His thoughts and mobility still disrupted by chemicals, Oaks “managed to stumble out of the institution when the taxi arrived, and that was the last time a psychiatric institution held me” (2001: para. 25).

Even though the DSM-III’s tectonic impact on biopsychiatric paradigms sits chronologically between Oaks’s experience on medication (early to mid-1970s) and my informants’ experiences on medication (mostly 1990s and 2000s), their respective accounts exhibit striking similarities that, in concert, destabilize the notion that modern chemicals are more “targeted,” and modern conventions less depersonalizing, than those of decades past. Of particular note is the frequency with which stories zeroed in on how biopsychiatric treatments sensitize people to their interior states, making them acutely aware of sensations and behaviours they feel are either unreflective of their authentic selves or simply foreign in origin. Several narrators alluded to feeling imprisoned within an uncooperative body whose self-destructive inclinations no longer hewed to familiar patterns (Nathan, Jared, Magda) and others spoke of feeling compelled, disembodied, or internally colonized by external agents: aliens, worms, possessive forces. These narratives are disconcerting for many reasons, not the least of which is that they stand in such clear contradistinction to the “changeling” narrative we explored in chapter 4. From my informants’ points of view, it was not “mental illness” that stole away their authentic personalities and left grotesque counterfeits in their place; it was, in a sense, “mental
health”—or at least the custodians and configurations of knowledge and practice that our society entrusts with safeguarding “mental health.”

Vanessa’s story is especially disturbing in light of the high premium that Western bioethical thought places on memory as a determinant of identity. To have two decades of memory stolen is to have one’s self stolen in a manner that is not merely metaphoric. Violations of memory can take many forms, and I want to suggest that Ryan’s silence can also be parsed through this lens. What was stolen from Ryan was not his neurological integrity; it was, as Olivia pointed out, an ambiguous identity that he had cherished, in which he was not “a known quantity.” Whenever Ryan would wax nostalgic about the life he had led prior to his encounter with psychiatry, it was evident that he relished the idea even if not always the reality of being beyond comprehension, of being unruly, out of control, and unknowable. To look back upon one’s life in the knowledge that one’s insurrectionary memories lead sequentially and ineluctably to psychiatric hospitalization is to look back upon a tainted narrative: as Vanessa realizes, “I will forever be seen by others through their ‘filter’ of ‘mental illness.’ Psychiatric labels stick.” Just as pain effects “a radical assault on language” when speakers want to describe their pain but lack adequate descriptors (Jackson 2003: 173), language can effect a radical assault on pain when speakers do not wish to describe their pain but have inadequate descriptors forced upon them.

Jackson (2003: 175) has pointed out that “language allows distance from experience, and while we may benefit from this feature when we try to gain control over aversive experiences, language does not reproduce the link between the experience and the ‘me’ undergoing it” (see also Clarke 2011, Streck 2003). Deirdre’s response to her counsellors’ repeated critiques of her rationality (“I don’t know, I don’t know, I don’t know”) can also be understood in this light. It is clear from her email that she fully grasps the rhetorical nature of her interrogators’ line of questioning. They were not trying to elicit explanations of why she dropped out of school and quit her job; they were trying to reorient her priorities toward goals that our society treats as self-evidently desirable and moral. Her insight, then, that “nothing else will make sense to them” is a poignant commentary on the de facto function of mental healthcare. She knows that her reasons for not graduating and working will be axiomatically disqualified from the domain of rationality precisely because she did these things. By refusing to answer the questions, Deirdre is in fact revealing her hyper-literacy in neoliberal norms: she knows that her words will make her more and not less susceptible to critique, so she says nothing (cf. Carr 2011). Unfortunately, in so doing, she likely confirms her diagnosticians’ suspicions that she is irrational, not to mention the Kirby Report’s worries about the costliness of her non-compliance.
As I have tried to suggest throughout this chapter, keeping secrets is a vital part of identity formation that is nonetheless increasingly medicalized in a culture that so privileges unambiguousness, extroversion, and explicitness. Jared’s insight about the equivalence that some clinicians draw between “recalcitrance” and “craziness” is salient here. In sliding a bit too readily from theory to practice, psychiatric personnel too often fail to ask themselves “about the possible consequences of labelling a certain behaviour one way or another, or even having to label it at all… There are moments when wisdom is silence” (Lambek 1992: 346). Indeed, the breathtaking extent to which concepts of self and personhood have been colonized with psychiatrized vocabularies has produced a cultural space in which only very few people can ever successfully perform “mental health,” in which freedom-through-health is both glorified and made impossible, and in which private coping methodologies become legitimate, even urgent, fodder for public commentary and censure.

4. Whither “Recovery”? 

Here, I return to problematizing the health/illness binary as it is conventionally used in mental health discussions. In Western bioethics, the tenet of “informed consent” asserts the inseparability of body and life, according to which a person ideally has the final say about “which medical interventions are made in her body” and is entitled “to determine the extent to which information about her body should be made available to others” (Ainslie 2000: 540). However, the standard scenario that emerges from the stories articulated above muddies the application of this tenet a bit, even if we suspend the question of whether or not the “mentally ill” are capable of something called consent. When the clinically acknowledged side-effects of prescription psychotropics—suicidal thoughts, anxiety, dread, uncontrollable sweating and shaking, unexplained surges of terror, insomnia, narcolepsy, hallucinations—so closely resemble classic symptoms of “mental illness” that the two are arguably indistinguishable, patients who consent to the administration of these drugs are in a sense consenting to becoming “unhealthy.” Access to healthcare professionals, timely diagnosis, and swift intervention did not restore my informants’ “mental health”; instead, these supposed privileges wreaked havoc on their health, in some cases confecting meaningful madness into a suddenly meaningless soup (“I don’t mind being suicidal; this was a totally different thing”) and denying others the right to philosophically valuable ambiguities.

89 As Carr (2011: 14) notes, drug users who are reluctant to share their thoughts in outpatient therapy sessions are frequently reminded that “secrets keep us sick.” I will argue in the next chapter that keeping secrets can also be a vital part of “recovery” processes that unfold outside the purview of medical expertise.
Is this because their “consent”—that is, for those who did consent—was “uninformed”? It is true that North American physicians apparently spend, on average, less than one minute explaining to patients the rationale for their prescribed treatments, and this can obviously lead to uninformed consent (Moore 2010: 25; see also Mock 2001). It is also true that many physicians are themselves unaware of the wide range of adverse effects that psychoactive drugs can induce, not least because of pharmaceutical firms’ intensive marketing campaigns (Paris 2008). I would suggest, however, that such a narrow circumscription of the problem evades an underlying issue. The notion that efficient, panoptical psychiatric services can save today’s “mental illness” sufferers from lifelong institutionalization denies the possibility that “recovery” can occur outside of, and indeed in spite of, the purview of medical expertise. To those who aspire to such a recovery, it is not the systemic unavailability of pharmacological information that obstructs “informed” consent; it is the systemic unavailability of other kinds of information.

In her memoir *Soul Survivor: A Personal Encounter with Psychiatry*, psychiatric survivor and activist Mary Maddock asserts that a key ingredient of her recovery from twenty years of hospitalizations, electroconvulsive treatments, and psychopharmaceutical dependence was “knowledge.” “It had been ignorance that had led me into the horrific world of psychiatry and now knowledge was leading me out” (Maddock and Maddock 2006: 135). She notes further that I began to read. Some of the books that enlightened me were: Toxic Psychiatry (Peter Breggin), Beyond Prozac (Terry Lynch), Users and Abusers of Psychiatry (Lucy Johnson), Beyond Fear (Dorothy Rowe), Insanity (Thomas Szasz), Coming Off Psychiatric Drugs (Peter Lehmann), Mad in America (Robert Whitaker), Choice Theory (William Glassner), They Say You’re Crazy (Paula Caplan), and Depression—an Emotion not a Disease (Michael Corry and Aine Tubridy). (Maddock and Maddock 2006: 135)

While working her way through these titles—most of which were authored by either psychiatric survivors or dissident healthcare professionals—Maddock weaned herself off of her medications and regained her ability to think clearly and sleep through the night for the first time in two decades. The above passage was striking to me because her basic formulation of the problem—*ignorance* had led her in, *knowledge* was leading her out—echoed almost word for word a refrain that I heard repeatedly during my fieldwork. However, although many of my interviewees did, in fact, credit their discovery of anti-psychiatric texts and ideologies with their ultimate recovery and liberation from psychiatry (see chapter 6), some did not encounter anti-psychiatry activism even once until well after their recovery. It was, on the contrary, their achievement of recovery

---

90 For example, Krista Maxwell (2011) has shown how urban indigenous healing movements in Canada conceptualize “recovery” as a historically situated achievement that involves reclamations of aboriginal cultural identity and social relations.
outside the auspices of the psychiatric system that made them receptive to anti-psychiatric literatures.

If psychiatric treatments often exacerbate mental anguish and sometimes permanently derail lives, what is it that allows people to recover from mental anguish and reassert control over their lives? This question must be addressed in the context of chapter 4’s analysis of a largely depoliticised national press, which I noted plays a key role in fragmenting and demobilizing public discourse around diverse topics that are, but do not appear to be, profoundly implicated in the “national mental health crisis.” The fact that the mainstream news media typically decline to analyze systemic relationships between seemingly disparate social problems (e.g. women’s marginality, geographic distributions of poverty, foreign policy positions, postcolonial humiliation, ecological problems, accessibility of different foods) does not mean that holistic analyses do not exist; it often means, however, that it takes more work to discover and acquaint oneself with them. Chapter 6 will therefore deal in large part with the rehabilitative properties of knowledgeability (i.e. discovering alternative sources of information, becoming literate in a multitude of topics), as well as way in which certain constellations of knowledge facilitate safety (i.e. privacy, financial stability) and community (i.e. discovering and developing meaningful relationships with like-minded others).

There is a wrinkle in this objective, however, which must be understood in light of this chapter’s illustrations of psychiatry’s evaluative reach. Naisargi Dave (2008: 387) has observed that “the point of activism is critique and the creation of a new, not just a reversed, morality.” Identifying a tension between “what might be and what must be… between the ethical and the moral” in modern political movements, Dave (2008: 389) points out that activists’ projects of innovating new relational possibilities and radically reshaping existing norms do not always jibe with existing moral imperatives. As noted in chapter 3, this tension has consistently been a sundering force in anti-psychiatric mobilizing: some parties argue that involuntary psychiatrization is sometimes necessary in a disabling and debilitating society, while others argue that the right of the individual to decide her own fate—whatever the cost—is and must always be inviolate. This ethical/moral tension is now additionally complicated by a new position that is emerging in Canadian mental health debates, which delineates “recovery” as a type of legal entitlement rather than an achievement, moral requisite, or even gift. As the Ontario Legislative Assembly’s Select Committee on Mental Health and Addictions (2010: 15) recently contended, the right that ought to be inviolate is not a person’s “right to autonomy” but her “right to be well.” In some situations, the Committee argues, “individuals need to be arrested in order
to receive care… some people will not avail themselves of such services because it is the nature of their condition to deny that they are ill … there are a number of psychiatric conditions for which a delay in treatment can result in an irreversible deterioration in health” (2010: 15). The Committee (2010: 16) then identifies “involuntary admission and treatment” as a key technique for ensuring that people can enjoy their right to be well of “harms that are not merely physical,” although this last phrase is not defined anywhere in the report.

What is key here is the jarring disconnect between defining “recovery” as integration into psychiatric reasoning and defining it as liberation from psychiatric reasoning. Medical sociologists have long noted that the shift toward deinstitutionalization in Western societies has been accompanied by the extension of preemptive and preventive technologies into virtually every branch of civil society (e.g. early childhood screening programs, genetic counselling and risk assessment, educational curricula for parents and teachers; see Danforth and Navarro 2001, Rose and Novas 2005). With the rise of the “community psychiatry” model, the costs of inpatient services have been increasingly defrayed with the aid of pharmaceuticals: in Ontario, for example, certain involuntary inpatients are now permitted to become outpatients on condition that they comply with rigorous polypharmaceutical regimens designed, or at least intended, to pacify their allegedly violent urges (Fabris 2011; Ontario Ministry of Health and Long-Term Care 2009a). In the neoliberal context, “community psychiatry” initiatives acquire a felicitous air, for they appear to serve the interests of the state (devolving care to the community is said to ease fiscal pressures on the welfare state; Rose 2001), the interests of employers whose profits are jeopardized by absenteeism and “presenteeism” (chapter 4), and even the interests of inpatients seeking freedom from institutional confinement (chapter 3). “Med compliance”—taking one’s medications diligently to avert future hospitalizations—becomes the key to freedom rather than a type of incarceration in itself. Madness becomes a fundamentally unalterable condition that can only ever be managed, never cured, let alone permanently reclaimed and removed from the psychiatric gaze. And people who are able to suffer and overcome on their own terms are, as we will see, once again required to choose between telling a story that violates key principles of “good citizenship” and telling no story at all.
Chapter 6
“It’s Not (Just) Me”: Transgressive Recoveries and the Politics of Compliance

1. The Either-Or Fallacy

“Sometimes, I wish—” Alyssa began hesitantly, before pausing to collect her thoughts. It was a chilly winter evening, and we were sitting on the floor of her living room, unpacking boxes and taking careful sips of hot apple cider from fat mugs that sat precariously on a stack of textbooks. She had just moved into a new apartment, and I was helping her to assemble some IKEA furniture. We had been working more or less wordlessly for about fifteen minutes as a Sarah McLachlan CD played in the background. When she paused mid-sentence, I glanced up at her. She smiled and shook her head, and we returned to the task at hand.

A few moments later, she tried again. “Sometimes, I wish—I wish I could say to people, ‘The only one who’s going to save you is you. You can’t just lie there, waiting for help.’”

The way she formulated this assertion surprised me. Alyssa was a friend of Olivia’s who occasionally attended Unhinged meetings to solicit feedback on her poetry. She did not have an official psychiatric history and thus did not identify as an actual “psychiatric survivor,” but rather as an “ally” to the survivor community. During the “go arounds” that preceded every meeting, I had noticed that she was often the first to reassure other participants that they were not responsible for the inequalities that had made their lives so challenging (“Look, it’s not you—it’s the system,” she would say). However, the story she revealed to me that evening was animated by a decidedly different logic, and in hindsight I believe it was intended as a private rejoinder to a statement that another Unhinged attendee, Fleming, had made the previous day. Fleming had a long history of truancy when it came to jobs and classes, and earlier that week he had deregistered, for the second time in six months, from a local career counselling program. “I’m not ready,” he had said. “I have too much baggage, I don’t have anyone to talk to. I can’t do this.” In response to Olivia’s encouragement (“Yes, you can”), Fleming had angrily and forcefully reiterated, with a pause punctuating the two syllables, “I can’t.”

About ten years ago, Alyssa told me, she had passed through a difficult period during which she suffered from anorexia, engaged in self-injury, was deeply depressed, and had what she called “horrible, compulsive urges.” At that time, she was a part-time university student in her late teens who lived with a group of friends in a rented house. Due to a combination of stressors and pressures, she became miserable in this environment. She had been balancing early morning classes with part-time jobs that required her to work evenings and nights, and the
chronic lack of sleep made her “a little crazy.” In addition, this had been her first time sharing a living space with people who were not her family, and the constant lack of privacy made her feel anxious. She felt that her housemates and their partners were watching and judging her, and she became increasingly secretive about her daily activities: refusing to eat unless alone, refusing to step into the kitchen if someone else was already using it, attempting to squeeze all of her household chores into the few hours each week when she was the only one at home. She began to fantasize about death and cry herself to sleep at night. However, she never revealed the extent of her distress to her parents or friends, nor to her long-time boyfriend, whom she broke up with when he began to lecture her about her refusal to eat in public.

Alyssa was emphatic that the key to her eventual recovery was a resolute belief that she “did not have a mental illness,” that she alone had control over her actions, and that “no one was coming to save me, so it was up to me.” She was equally emphatic that if she had turned to psychiatry for help at this critical juncture in her life, she would have never have truly recovered.

I know it’s not politically correct and at the same time I had no choice but to save myself. In this society, there are no safe spaces for help, no one cuts you any slack unless you want to break down and say, ‘I’m sick,’ and I was not willing to say it, it would have been a lie. …If I had gotten sucked into the mental health system, I wouldn’t be here, you know this as well as I do. I’d be living in my mom’s basement, no degree, no savings, no job, no future, SSRIs all day, lying on the couch, in and out of hospital, and you know as many people as I do who—where this is what took place. … I’m not claiming everyone has to, it’s just, there are some things you can do for yourself, when you break out of this helpless mindset.

After recording her explanation, we returned to deciphering IKEA’s assembly instructions, and she gently steered the conversation away from this subject. About an hour later, we both stood back to admire the wall of bookcases we had constructed for her new place.

“If you want something done right…” Alyssa said in satisfaction, leaving the second half of the aphorism unspoken (“you have to do it yourself”). Then, as if suddenly realizing that the remark could be interpreted as a subtle critique of those unable to “do it themselves,” she turned to me and said, “I want you to know that what I told you tonight, I wouldn’t have, if I didn’t think you’d understand. I would never say it in public, never. I’m not trying to judge anyone.”

She took our empty mugs to her kitchenette, and added with a quiet sigh, “But, you know—you can’t deny your own life.”

* * *

Alyssa’s story is fraught with ethical tensions that resurfaced in many other contexts during my fieldwork, and it is clear from the many hedges in her narrative (“I know it’s not politically correct,” “I’m not claiming everyone has to,” “I’m not trying to judge anyone”) that she saw her story as, in some ways, anathematic to the modern view of “mental disorders” as biological and
thus involuntary states. At first glance, the primary theme of Alyssa’s story would seem to be that of willpower, of the triumph of personal effort over structural constraint, and her narrative indeed echoes late capitalist exhortations to inure oneself to the disappointments of modern life and to learn to “tolerate contingency with cultivated skill” (Chua 2011: 131). However, I want to suggest that the way in which Alyssa recounted her story exemplifies a second, equally important theme: that of the politically problematic narrative, the life story whose causal thrust relies on logics that transgress key moral precepts of its anticipated listeners and which thus becomes publicly unrevealable. This observation may sound counterintuitive in light of the widespread legitimacy that the Protestant work ethic and neoliberal valorizations of personal responsibility enjoy in our society (Kirmayer 2002, Reith 2004). Alyssa’s insistence that “there are some things you can do for yourself” would seem to align nicely with rugged North American parables about pulling oneself up by one’s bootstraps. If Alyssa is critiquing those who “just lie there, waiting for help,” isn’t she advocating the reactionary stance that hard work and determination are reliable bulwarks against trauma and suffering?

There is a false dichotomy at play here, whereby “illness” and “weakness” are put into direct competition in causal accounts of desolating psychological distress, and which this chapter challenges, along with two other problematic binaries rooted in biodeterministic mental illness models: “insight” versus “poor insight,” and “compliance” versus “non-compliance.” Alyssa, who paints herself into a corner by rejecting biological determinism, feels obliged to accept the neoliberal claim that individuals must “fashion their own futures through their decisions” (Gershon 2011: 540). The fact that such decisions must be made within pre-existing infrastructures that shape the parameters of possibility recedes into the background under this logic, which accepts “deregulation, privatization, and withdrawal of the state from many areas of social provision” as accomplished facts (Harvey 2005: 3). But if a person’s failures in life can be explained by her recalcitrant refusal to make use of services that are available—like psychiatric services—doesn’t this mean that she is either unwilling or unable to make sound decisions? What assumptions must we unpack to see the fallacies in this sort of thinking?

In previous chapters, I suggested that the primacy of narratives around authentic and inauthentic selves in mainstream news coverage of “mental illness” discredits psychiatric survivors who value their pain, alienation, and deviance (“illness”) and who in fact identify biomedical interventions as sources of somatic harm and grotesque feelings of internal inauthenticity (“treatment”). When my informants related their troubling descriptions of what it felt like to be “on” various psychopharmaceutical compounds, it was not lost on them that their
clinicians’ intended endpoint (“recovery”) typically required them to become lifelong consumers of these compounds (“med compliance”). Many psychiatric survivors have thus come to view their supposed benefactors—doctors, nurses, social workers, counsellors, and other supposed professional allies—with considerable suspicion, based on firsthand knowledge of what their “help” can entail. In chapter 5, I noted that this dynamic is shaped by a disconnect between defining “recovery” as integration into psychiatric reasoning and defining it as liberation from psychiatric reasoning. It is this disconnect to which I now turn, with an eye to demedicalizing the preferences of “unruly” mental patients, and revealing how the degree of acquiescence they display can be explained in terms of factors beyond the biomedical purview. In what follows, I begin by reviewing current theorizations of patient “insight,” which, as a clinical assessment tool, has been known to make mental health workers overly sensitive to minute differences between their own attitudes and intuitions and those of patients who are predefined as unreliable narrators (Velpry 2008). By analyzing stories that traverse the sinuous road from pathologized difference to politicized dissidence, I then consider how a preoccupation with the authenticity of unusual opinions and aspirations can make stories about non-medical recovery “unhearable” to friends and family—and sometimes to other psychiatric survivors—and eventually unrevealable altogether as the psychiatrized narrator tires of being disbelieved or invalidated. Rather than serving to reintegrate psychiatrized people into their communities, biomedical discourses that attribute deviance to “the illness… not the individual” (Chung 2009: A7, see chapter 4) can thus instead compound a deviant person’s isolation, obliging those who are wary of external “cures” to protect themselves with silence and secrecy. In so doing, I make a case for explanatory rubrics that are irreducible to either illness or weakness, and unpack the extreme sense of constraint that marked many narrators’ efforts to tell acceptable stories about existential pain, which I attribute to the conceptual monopoly that biopsychiatry has over the definition of “recovery.”

A central part of this exercise is unearthing the role of alternative sources of information in psychiatric survivors’ journeys toward what they come to see as healthy. As discussed in chapter 4, mainstream news outlets must maintain high readership levels in order to secure advertising revenues, and one method of maintaining a broad appeal is to focus heavily on fashionable, depoliticised topics and to exclude robustly historicized analyses and politically disturbing content from “special reports” on social issues. In earlier decades, a thriving anti-psychiatric press furnished readers with alternative frameworks for understanding their experiences of hardship (e.g. anti-capitalism, feminism, prison abolitionism), and as one reader pointed out, “Without their radical perspective, it is likely that many of us in the movement
would lack the political analysis that links psychiatric oppression with the broad political and economic oppression in our society” (McKinnon 1986: 10, PR). The more time I spent in the field, the clearer it became to me that many of my own informants were advancing similar claims about a wide range of alternative educational resources, both textual and interpersonal. As I hope to demonstrate, psychiatric survivors’ alienation from the political mainstream—and their hesitancy to publicize life stories that they know will make them vulnerable to various kinds of moral critique—is not so difficult to understand in light of the mainstream media’s characterization of “mental illness” as biodeterministic and intractable in the absence of expert guidance, and the media’s refusal to engage seriously with topics of vital significance to people seeking not charity but dignity in a broad sense.

2. The Canons of Recovery

2.1 Unpacking Insight and Compliance

Alyssa’s story of achieving recovery outside the medical purview was grounded in the utter conviction that the act of confessing that she was “sick” would lead ineluctably to a bleak future of unemployment, poverty, and chronic illness (“SSRIs all day… in and out of hospital”), which in some respects echoes Ian Hacking’s (1999: 104) insight that psychiatric classifications may “change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified.” In stark contrast with Alyssa’s stance, the American Psychiatric Association asserts that the refusal to acknowledge that one is sick is “one of the best predictors of poor outcome” for a patient (quoted in Roe and Lachman 2005: 225), and such refusals can indeed have significant consequences in the context of a psychiatric evaluation. Although clinicians currently make use of heterogeneous definitions of “insight,” standard definitions characterize it as a property possessed by psychiatric patients who exhibit a strong level of agreement with clinical assessments, and link it closely with “compliance” by contending that poor insight “predisposes the individual to noncompliance with treatment” (American Psychiatric Association 2000: 304; see also Applbaum 2009). 91 Curiously, although psychiatrists use the word “compliance” to refer to patients’ dutiful consumption of medication in its prescribed dosages and overall adherence to a treatment plan, the same word has a very different definition in the addictions literature. In addiction studies, “compliance” describes situations where patients tell their therapists what they want to hear while continuing to “inwardly believe themselves innocent of ‘all charges’ relating to addiction” (Lovern 1991, quoted in Carr 2011: 131). My use of the term follows the mainstream psychiatric definition: compliance is adherence to treatment. However, as will be seen, the theme embodied by the second definition—giving lip service to experts’ instructions while secretly rejecting them—recurs throughout psychiatric survivors’ narratives. I will refer to this phenomenon as “playacting compliance.”
typical for psychiatric case notes to refer to “good,” “partial,” “poor,” or “no” insight, with limited accompanying explanation, suggesting that the “quantification of presence or absence” is the foremost consideration when profiling a patient’s insight (McCabe and Quayle 2002: 14). Successful performances of “good” insight typically involve three components: (1) patients should be able to reinterpret symptoms (e.g. delusions, abnormal preoccupations, emotional outbursts, depression) as signs of an underlying psychiatric illness, (2) they should recognize that untreated symptoms will have negative social consequences, and (3) they should recognize that treatments are beneficial and comply with them (Amador and David 2004, David 1990, Roe and Lachman 2005). In equating rational personhood with the willingness to agree that one’s interior wellness is somehow compromised—and to defer to the evaluators’ expertise in pursuit of recovery—the “insight” construct can acquire a Goffmanian master status in clinical interactions, and can intensely colour the way in which observers interpret any claims, desires, speculations, or aversions that a patient happens to express. Since it is thought that people who are unable to appreciate the consequences of their choices can neither be safely entrusted with the right to choose nor penalized for past choices, “insight” also becomes “an essential ingredient to competency for informed consent and in criminal prosecutions” (Tranulis et al. 2009: 16), as well as a major determinant of outcome in hearings for Involuntary Outpatient Committal programs (Fabris 2011, McCabe and Quayle 2002).

Social scientists have critiqued the etiological and juridical soundness of the “insight” construct by pointing out that it is not a stable attribute that can be abstracted from patients on the basis of objective metrics. Because the level of perspectival agreement between a patients and evaluators plays such a cardinal role in determinations of insight, authors have pointed out that an intolerance for dissent is always latent in such determinations (Rabinowitz 1994, Roe and Lachman 2005: 225, Tranulis et al. 2009). Patients are often aware that their freedom may be at stake, and may be motivated to produce “correct” responses to physicians’ queries to avoid displeasing those who have power over them, whether or not those responses accurately reflect their experiences (as Olivia once mockingly put it, “The meds are working! Can you let me out now?”; see also Estroff et al. 1991, Saris 1995). At the same time, patients who are too eager to conform risk being discredited as pathologically passive. To achieve a designation of good insight, “a patient has to walk a fine line between showing autonomy and conforming to the staff’s ideas on the limits of the patient’s capacities” (Velpry 2008: 254). Accordingly, the task of persuading clinicians that one is a rational, reliable narrator can require a great deal of performative investment and rhetorical skill, and many former inpatients have attested to the
need to produce carefully tailored “false confessions,” playacting compliance, and concealing one’s true experiences in an effort to liberate themselves from involuntary confinement:

I never doubted my own sanity. … As soon as I had sufficiently recovered from the confusion caused by the shocks and the drugs, as soon as I had recuperated from the aftereffects of the tortures, I decided I would play along with the doctors in order to get out of there. I lied to them. When you lie to psychiatrists in this way, they accept it as the truth. But when you tell the truth—that the treatments are harmful, that you’re not sick—that’s regarded as ‘hostility,’ and as further evidence of the fact that the disease has persisted, or that you have ‘lack of insight’ (Leonard Frank, quoted in Chamberlin 1978: 74-75).

Christmas was coming up and I finally realized that I had to submit and play the game if I was ever going to get out. … I even went to the line up at the window to get my drugs without a fuss. When Dr. King arrived we chatted about my apparent drastic change in attitude. He told me how impressed he was with me. … When you change your behavior—specifically, submit, comply and swallow on demand—then you’re not considered ‘sick.’ … Since this was the day that Dr. King said he might let me go home for the whole week-end, I was eager to suck-up big time when he came to visit. He said that my efforts to follow his orders were to be commended... I had passed the test and could go home for the weekend (Funk 1998: 78-80).

“Have you been depressed recently?” she asks. … “No.” I respond, like my tonsils are being checked. “Have you had strange thoughts?” “No.” I am glad to be saying that, playing through the exercise as instructed. I do not say about the ravens, or the feeling of wings on my face, or knowing when the lights will change. I do not say about running empty for miles just to choke nine metres from the gas station. I do not say about Death in the delivery van, or in the news (Fabris 2011: 14-15).

I finally decided to tell my psychiatrist that I just wanted to clean my house and take care of my baby. As soon as I said that, he declared, “You’re much better now,” and promptly discharged me. I’m quite sure that I wouldn’t have gotten out of Lakeshore if I hadn’t told the psychiatrist that I wanted to play housecleaner, cook and mother. … If I couldn’t have let go and screamed my head off, I probably would have felt a lot better than being subdued by shock and tranquilizers. And obediently sitting still all day like a good girl is just not my idea of good mental health (Harries 1988: 40).

Everything I said was discounted, denigrated. My ex-boyfriend and my family members’ lies were taken as truth and my truths were taken as lies or delusions or hallucinations and symptoms of my insanity. … The angrier I got about being discredited and mistreated the more I was deemed insane and “labile”… It’s a lesson I will carry with me for the rest of my life. After the Haldol assault [forced injection of a drug] I learned real fast to keep my mouth shut around people like this “mad” psychiatrist. I was in terror: scared for my life and sanity. From them on I more than cooperated. I kissed ass and got the hell out of there as soon as I could (Gaines 2001: para. 18, 21-22).

It is not only those striving to win a swift release from psychiatric wards who feel the need to perform for the benefit of their clinicians. As Velpry (2008: 238) has noted, being granted the status of a rational narrator “gives access to the most valued model of care, one that is based on partnership,” and patients whose words and actions deviate strongly from rehabilitative expectations are less likely to be taken seriously in negotiations about their care (see also Young 1995). Deirdre, whose inpatient experiences were far from ideal (“If you play the game, you can get out. But you’ve not been given any new tools for facing the world,” see chapter 5), had nonetheless voluntarily checked herself into a psychiatric unit on two separate occasions. In each
case, what she had sought was “some space, to breathe and just work things out,” and, in each case, she eventually regretted her decision to seek sanctuary in an institution:

   They put me through one work-up [evaluation] after another [and] I said, ‘Please stop—I don’t want more meds. Please, just give me a room and leave me be.’ And the nurse kind of laughed a little bit, he went, ‘Sweetie, this is why you’re here. You want to be well, we worry when it seems you don’t.’ … They sent me to a number of psychologists and I guess case workers before I caught on—to how to say the things they want to hear instead of what I wanted to say. It’s something that I held it for years after this. Go along with things, you don’t complain, cause it goes in your chart [and] they always throw it back at you, that you’re not treatment compliant.

Despite Deirdre’s many critiques of the psychiatric system, she considered herself an active client of the system and she regularly availed herself of its various branches in pursuit of mental health. Thus, in the episode described above, it was not escape from forcible hospitalization that she sought, but simply “a room” and some privacy. To her clinical evaluator, however, her dread of medications signalled a potential lack of insight (“You want to be well, we worry when it seems you don’t”). Deirdre was emphatic that her gradual accommodation to the preferences of hospital staff was not a result of enhanced insight, but rather of an aversion to having her words used against her (“cause it goes in your chart… they always throw it back at you”). In Deirdre’s account and in the five preceding excerpts, the clinicians who are authorized to make determinations about the soundness of their thoughts and desires are not seen as partners in the quest for “recovery,” but adversaries to be outwitted, thwarted, or avoided. My point here is neither that clinicians should indeed be viewed in this light, nor that they do their jobs in anything less than good faith. I wish simply to draw attention to the ways in which a conception of “insight” as a clearly defined state-of-mind can transform the goal of eliciting “insight” into an overriding therapeutic endpoint in and of itself (see Velpry 2008, Young 1995), thereby incentivizing patients to please staff by “playing the game” and learning how to pass ritualized tests. Patients who achieve their release by “playing the game” can later find that the stratagem has backfired, as their feigned admissions of illness and pretended compliance end up establishing a idealized benchmark of “mental health” to which friends and family will later hold them. As one interviewee put it, “If you say it’s [the treatments are] helping, they let you out. If you get on the outside and say, ‘Listen, I was lying,’ they think you’ve relapsed.” The way in which suspicions of relapse and denial can delegitimize survivors’ stories will be addressed later in this chapter.

Determinations of patient insight are closely linked with determinations of patient credibility, and evaluations thereof can be highly reliant on the life experiences and pre-theoretical assumptions that diagnosticians bring to the clinical encounter. Velpry (2008: 246)
describes a revealing case study from a French supportive housing program for psychiatric outpatients: one resident complained to staff about the presence of mice, while another complained about the smell of Chinese cooking wafting into his apartment each morning. The first resident was deemed credible, because a staff psychologist agreed that the building was poorly maintained; the second resident was deemed “delusional” because the psychologist thought it unlikely that such smells would be produced in the mornings, and recalled that this resident had previously made racist remarks. What is key is that the staff made these judgements without determining the empirical veracity of the statements: they did not themselves see any mice or smell any odours, but nonetheless decided that one complaint had a basis in reality and the other did not. Rabinowitz (1994) has described similar cases in which field psychiatrists from New York City’s Visiting Psychiatric Service (VPS) relied excessively on observations that would confirm poor insight and incompetence while ignoring counterevidence or alternative hypotheses. For instance, a seemingly confused woman who was deemed “incapable… with no meaningful hope of recovery” was later discovered to have an unrecognized hearing impairment (Rabinowitz 1994: 166). Another woman was declared delusional and incapable of managing her property and person because she claimed to have thirty-five patents and worried that her landlord was secretly taping her. It was later discovered that she did have thirty-five patents, and that her landlord was in fact taping her (Rabinowitz 1994: 168-169). Additional examples abound, such as the case of a Turkish refugee who was denied release from a Canadian psychiatric facility because he expressed “delusional” concerns about organ theft and had “unrealistic” aspirations of marriage; his clinicians later discovered that illicit organ trafficking is widespread in Turkey and that he did, in fact, have a fiancée in Germany (Munger et al. 2008).

The crucial point here is that patients’ narratives can be rendered overly exotic—transformed from humdrum complaints and comments about daily life into alarming hints of illness—by physicians trained to maintain a distinction between the social, situated knowledge of patients and the asocial, “real knowledge” of professional medical curricula (Taylor 2003: 556, emphasis in original). Good (1994: 78) has similarly suggested that, in some ways, physicians establish their professional credibility at the expense of their patients’ credibility, by learning to write clinical narratives in a way “that justifies the systematic discounting of the patient’s

---

92 This woman ultimately succeeded in contesting the city’s petition for guardianship of her property and person because she was wealthy enough to mobilize a robust legal defence. Poorer subjects of VPS evaluations were typically less able to protect themselves from unwarranted and/or unwanted psychiatric interventions (Rabinowitz 1994: 170).
narrative.” Under a medicalized gaze, the very act of speaking always already entails potential judgement, whereby patients’ claims are continuously monitored for signs of grandiosity, paranoia, and so on (Morrison 2005: 22-23; see also Barrett 1988). Thus, a major complicating factor in adjudications of insight is the fact that, when asked to reflect on their interior state, “the patient is not alone, but faces the clinician” (Tranulis et al. 2009: 19). As a symptom, “level of insight” is subject to the observer’s paradox to an extent that far exceeds that of somatic signifiers such as broken bones or bruises, whose manifestations are less contingent on the quality of patient-clinician interactions. By framing insight as a static, binary property that can be wholly absent (“lack of insight”) and by conflating a patient’s refusal to accept a diagnosis with an incapacity for inferential thinking, psychiatric evaluators run the risk of pathologizing the healthy skepticism that clients of other medical specialties are in fact encouraged to express when “shopping” for healthcare in a savvy manner (e.g. asking for second and third opinions, asking about a physician’s credentials and qualifications, presenting counterevidence to test the accuracy of a diagnosis, voicing concerns about inadequate facilities; see Hall and Schneider 2008, Ha and Lee 2011). Given that it is part of Western bioethical practice to treat patients as objects to be spoken for by medical experts even when they are not psychiatric patients (as Ainslie 2000 reminds us, ethnographers typically approach doctors or administrators, and not patients, when seeking initial authorization to study the internal activities of a clinic), resistant patients whose unruliness can be blamed on compromised rational faculties face particularly daunting challenges. As “mental illness is deemed to impair the very capacity to have and express a view,” psychiatric staff may come to believe that “they know what [a patient’s] ‘true’ opinion is, despite what she says,” and, consequently, “if a statement is not recognized as valid by the professionals, it will be attributed not to the patient’s insight but, rather, to the illness” (Velpry 2008: 243-245).

The epidemiological repercussions of the “insight” construct are diverse. There is growing evidence that an excessive preoccupation with patients’ acceptance of an illness label can have deleterious effects on patients’ overall health outcomes, due in part to the widespread consensus that such labels represent biologically fixed conditions. Read et al. (2006) have argued that the prevalence of genetic and neurochemical explanations of “mental illness” in public discourse is positively correlated with increased prejudice, fear, stigma, and a desire for distance among audiences of such discourses (i.e. the more people believe that there is something wrong with the brains of the “mentally ill,” the more frightened and harsh they become toward them; see also Read and Harré 2001). Read et al.’s findings may seem to contradict Tanya Luhrmann’s
(2001: 8) astute identification of biology as “the great moral loophole of our age,” in that “if something is in the body, an individual cannot be blamed; the body is always morally innocent.” However, the contradiction recedes when a corollary of Luhrmann’s insight is made explicit: if a person is sufficiently biologically deviant, she cannot control what she does; if she cannot control what she does, there is no way to reason with her, and it may be justifiable to shun, confine, or ostracize her, since there is no way to know what she will or won’t do (or so the logic goes).  

As observed in a recent review of the literature on ineffective anti-stigma strategies,

Viewing disorder as immutable may encourage pessimism about the sufferer, viewing it as categorically distinct from normality may foster distancing and rejection, and viewing it as biologically based may stoke fears that the affected person is unpredictable, at the mercy of an untamed nature (Haslam 2003: 637-638).

Due perhaps to both social ostracism and internalized stereotypes, patients who manifest good “insight” have commonly been found to manifest lower self-esteem when compared with patients with “poor insight,” a correlation that is especially strong in patients diagnosed with “serious mental illnesses” (Kirmayer and Corin 1998, Lally 1989, Tranulis et al. 2009). More alarmingly, greater “insight” has been correlated with significantly higher suicide rates in subpopulations where suicide rates are already high (e.g. patients diagnosed with major depression, schizophrenia; see Amador et al. 1996, Crumlish et al. 2005, Kim et al. 2003). Clinical studies have also established a close correlation between “greater unawareness of illness” and “less depressive symptomatology,” particularly in people who are less aware of the social stigmas associated with their mental disorder (Roe and Lachman 2005: 225, in reference

---

93 Studies have repeatedly shown that mental disorders that are unaccompanied by substance abuse actually “account for a miniscule portion of the violence that afflicts American society” (Monahan and Arnold 1996: 67; see also Elbogen and Johnson 2009, Harris and Rice 1997, Juss 1997) and that, contrary to sensationalistic media depictions, the “mentally ill” are far more likely to be victims than perpetrators of violent crime (Campbell et al. 1994; Marley and Buila 2001). Bonnie Burstow has noted that the calls for vigilance that often accompany news reportage on the link between “mental illness” and violence are illogical: “while violence is not disproportionately connected with mental illness, masculinity is disproportionately associated with violence and [yet] we are not asking people to be alert to the early warning signs of masculinity” (quoted in Psychiatric Survivor Archives of Toronto 2011: 7). And, because substance abusers tend to have endured socioeconomic hardships early in life, blaming them for street violence without addressing underlying causes—as in “the war on drugs”—may amount to “punishing people for having been abused” and impoverished (Goodman and Maté 2010: para. 20).

94 In the mainstream psychiatric literature, the term “serious mental illness” (“SMI,” sometimes “serious and persistent mental illness or “SMPI”) can refer to any DSM disorder that substantially interferes with a subject’s social functioning (Kessler et al. 2003). Diagnoses that are most commonly associated with this term include schizophrenia, schizoaffective disorders, bipolar disorder, major depression, severe anxiety and panic disorders, obsessive compulsive disorder, borderline personality disorder, dual disorders (substance abuse combined with a mental illness diagnosis), post-traumatic stress disorder, or some combination thereof (Wang et al. 2002; see also Piat 2009; Ontario Ministry of Health and Long-Term Care 2009b; Morrison 2005: xi-xii; National Alliance on Mental Illness 2011). The fact that essentially any disorder can be an “SMI” arises from the DSM-III’s (and all subsequent editions’) equation of mental illness with social and occupational disability, degrees of which are defined in the manual’s Global Assessment of Functioning.
to Moore et al. 1999 and Schwartz 2001; see also Mechanic et al. 1994, O’Mahony 1982). On the other hand, it is true that receiving a diagnostic label can prompt feelings of validation (e.g. a sense of relief at “finally finding out what the problem really is,” Danforth and Navarro 2001: 185), and it is for this reason that patients and their families can sometimes become forceful advocates of biological explanations (Young 2008: 299). However, the diagnosed subject’s sense of validation tends to endure over time only when their volitional impairment is understood to be moderate and mainly situational (e.g. ADHD, SAD, postpartum depression), rather than severe and incessant (e.g. OCD, major depression, personality disorders, schizophrenia spectrum disorders, severe anxiety disorders; see Kravetz et al. 2000). As several studies suggest, the optimistic feelings elicited by any official diagnosis often wanes when self-labeling persists over a long period, as the patient gradually discovers that her label is altering her interpersonal relationships, career opportunities, financial prospects, and credibility in healthcare contexts, as well as her sense of control over her future (Hasson-Ohayon et al. 2006, Kravetz et al. 2000, Stoppard and Gammell 2003; see also Kutchins and Kirk 1997).

In short, it may be true that good “insight” facilitates “compliance with treatment” (American Psychiatric Association 2000: 304), but it may also lead to demoralization and a loss of faith in one’s abilities, future, potential, and worthiness. A patient’s acceptance that his mind is “ill” and that his self is therefore “ill” can easily devolve into a resigned belief that he is beyond hope, and this belief can be exacerbated by clinicians’ pessimistic attitudes toward those identified as chronically ill, as well as the tendency of hospital personnel to talk to each other about psychiatric inpatients’ prognoses in their presence (Capponi 2003, Fabris 2011).95 Estroff (1992: 223) has noted that, following a diagnosis of serious mental illness, “a part-time or periodically psychotic person can become a full-time crazy person in identity and being.” Rosenhan (1973: 254) has similarly noted that a psychiatric diagnosis can act as “a self-fulfilling prophecy,” through which a patient eventually comes to accept a durable illness label “with all of its surplus meanings and expectations, and behaves accordingly.” Some researchers have found

95 A patient’s knowledge of staff members’ predictions can also be a motivating force. Jim Gottstein, a Harvard Law School alumnus, noted that during his own hospitalization, “When I told members of the staff that I was an attorney, some didn’t believe me and the others said I would never do that again” (1998: para. 3). When he refused to agree with this prediction, he was told that he was “in denial.” After this experience, Gottstein devoted his life to legal advocacy for psychiatric patients. He is best known for subpoenaing internal Eli Lilly documents and emails in 2006, which according to the New York Times demonstrated that the company had wilfully misrepresented the metabolic risks of their top-selling antipsychotic Zyprexa (Berenson 2006). This led directly to the revelations that Zyprexa had potentially caused a significant percentage of users to develop diabetes, and thus made it possible for Zyprexa users to file and win a series of class action lawsuits against Eli Lilly in 2007 and 2008 (Berenson 2007, Harris and Berenson 2009, Winsa 2008; see also chapter 4).
that a refusal to endorse an illness label can therefore be an adaptive response, especially for patients who see no resemblance between their phenomenological experiences and the DSM’s objectified symptomatological descriptions (Tranulis et al. 2009: 19, Roe and Lachman 2005). From clinicians’ point of view, however, a patient’s preference to be identified as unusual rather than as sick can signal “an unrealistically positive view of the self and an exaggerated perception of self-control… [which] will be attributed to poor insight” (McCabe and Quayle 2002: 15).

Mental illness labels can thus become

the central, overwhelming aspect of the person’s social identity in a way that does not permit any other part of that person’s story to be told, the lens through which all accounts are viewed, the frame to every self-portrait (Susan Stefan, quoted in Andre 2009: 13).

It is perhaps for this reason that cross-cultural analysts of serious mental illness are routinely led to “the consistent—and unexpected—finding of better outcome in the developing than in the developed world” (Hopper 1991: 299; see also Hopper 2004, Jenkins and Barrett 2004). As Byron Good explains, “Where such illness is considered inevitably chronic, an essential part of the self that cannot be altered (e.g. where the individual is considered ‘a schizophrenic’), the illness is more likely to be chronic” (1997: 233-234, emphasis in original). Luhrmann (2007: 146) has likewise called attention to the possibility that the Western treatment paradigm “may make things significantly worse, and possibly even turn psychotic reactivity (the possibility for a brief psychotic reaction) into chronic clienthood, and that it may do so by repeatedly creating the conditions for social defeat.” That is, reducing conditions like schizophrenia to “bad genetic luck” or a “broken brain” obscures their non-biological determinants, encourages dehumanizing stereotypes, and leads sufferers to appear/feel wholly vanquished (Luhrmann 2007: 139, Kleinman 2004).

Other kinds of self-loathing can result from a patient’s “insightful” agreement that she has a mental illness, as evidenced in the below excerpt from a discussion I had with Magda, who had been both anorexic and bulimic. The daughter of a woman (Armaghan) who regularly attended Acceptance meetings, Magda hoped to one day have a family and to live “a normal life,” but she felt that her biological constitution could potentially return to haunt her even if she fully recovered from her difficulties:

But I don’t think I should have children, cause if even a little part of this is bad genes or whatever, I mean—my big fear would be if I have a daughter, that she’s gonna inherit my eating disorder, right? And that, like, people will treat her like they treat me, like if she does what I do. It would be my fault, right, for knowing better, and letting it happen, like with my eyes open.
Magda acknowledges that her “mental illness” may have biological, heritable determinants that could be reactivated in a future child, and she displays remarkable foresight in anticipating this potential outcome and assuming responsibility for it in advance. Her unwillingness to pass on “bad genes… with my eyes open” indicates that she is sensitive to the consequences of her choices and is willing to limit her aspirations on the basis of projected realities linked with her “illness.” During my interviews with her, Magda made her intense resentment of psychiatric treatments and her antipathy toward mental health ideologies abundantly clear (“I’m not a puzzle, and I don’t want to be cured,” see chapter 5). However, she openly described herself as “mentally ill,” and never explicitly disavowed the illness identity. Her recognition of her “mental illness” and acknowledgement of its social consequences would seem to meet two of the three basic components of patient insight outlined above. Yet, it is precisely her agreement that she is “ill” that has led to her resigned belief that something immutably pathological inheres in her genes. The extent to which a belief that the “mentally ill” are ontologically distinct beings pervades everyday thinking also came into sharp relief during a conversation with a family member of one of my key informants, who lamented to me that, “When you’re in a relationship with someone with a mental illness, you’re in a relationship with an illness, not a person” (emphasis mine). The clear distinction drawn here between “an illness” and “a person” brings to mind Jackson’s (2003: 185) eloquent reminder that, “It is not actually the case that the sick do not speak; rather, when they speak they are seen as making no sense, because the illness has taken charge and has the floor” (see also Kleinman 1988). As we will see, the belief that mental illnesses are ventriloquizing their victims has major implications for what kinds of narratives psychiatrized people can and cannot comfortably share.

The upshot of the present discussion is threefold. First, by directly linking “treatment compliance” with “insight,” psychiatric discourses systematically conceal a wide range of other variables that can shape a person’s disinclination to comply with treatments. As McCabe and Quayle (2002: 15) point out, “non-compliance may be understood as rational choice rather than irrational action… particularly given the side-effects of long-term psychotropic medication [since] many people find these more distressing than the original symptoms for which they were treated.” And, as Applbaum (2009: 109) notes, “in contrast with other areas of medicine, psychiatric drugs are often used to improve psychological well-being in a trade-off against physical health.” Even in instances where patients do not find medications intolerable, a refusal

96 See chapter 5. It is important to note that “side-effects” is not just a euphemism for “discomfort,” which some might argue is a small price to pay for psychological wellness, but can also refer to suicidal urges, which would seem to defeat the point of the medication (Wooltorton 2003, Whitaker 2002; see also chapter 7).
to comply with prescribed treatments can be motivated by sundry factors that are not obvious to clinicians, some of which will be explored shortly. The linearity of the “insight” construct (good, partial, poor, none) may thus impair the “insight” of the psychiatric gaze, which by focusing narrowly on the effort to meet a particular conception of science has generated an unscientific tendency to ignore large amounts of data that are difficult to measure reliably using standard methodological tools, but which might nonetheless be important (Roe and Lachman 2005: 223).

Second, a corollary of the widespread finding that “good insight” is linked with poorer self-esteem is that “poor insight” is widely linked with higher self-esteem (Tranulis et al. 2009). Indeed, several of my informants depicted their refusal to accept a diagnostic or prognostic judgement as a watershed moment in their quests for meaningful lives, even (or especially) when their resistance was immediately seized upon as evidence-of-illness by well-intentioned observers. Without meaning to reify clinical vocabularies, I want to suggest that “non-compliance” writ large—dissenting from authoritative perspectives, holding fast to valued madness experiences, breaking with received wisdom about how to manage one’s “illness” despite penalties and reprimands—lies at the heart of many psychiatric survivors’ stories of lasting recovery and political discovery. Third, because the permeation of psychiatrized thinking throughout civil society has led us to discern a pathway to “common goals, such as promoting healthy and harmonious families or enhancing productivity” in psychiatric interventions and pharmaceutical innovations (Eghigian 2011: 203; see also Lakoff 2008, Petryna and Kleinman 2006), it is difficult for people whose lives have been shaped by anger, pain, and alienation to find ratification for stories that neither disavow those dysphoric feelings, nor endorse the “global monoculture of happiness in which we are all enjoined to work to achieve the good life, which is understood to reside in being pain free, completely comfortable, and ready and able to acquire and consume the greatest quantity and variety of the newest goods and fashions” (Kirmayer 2002: 316).

2.2 Diminishing Returns: The Costs and Benefits of Non-Compliance

“Come back here! You can’t fly. You’re just a caterpillar!”
(discourse in cartoon on front cover of Phoenix Rising, vol. 3, no. 4)

The above quote is the text to the cover illustration of the spring 1983 Phoenix Rising issue. The illustration depicts a woman and a man with a large butterfly net who are yelling and gesturing into the distance. The target of their admonishment/astonishment does not appear on-panel; the “caterpillar” who is supposed to be unable to fly is long gone (see Figure 6.1 in Appendix II). When I encountered this cartoon during my archival research, I was reminded of a story that
Olivia had told me several months earlier. During her second hospitalization, her psychiatrist had reminded her that a failure to stick to her prescribed regimen of antipsychotics and mood stabilizers would inevitably result in a relapse (“Just like a diabetic cannot live without insulin, you will never be able to live without your medication. Stay on your meds, or we are going to be seeing a lot of each other,” see chapter 5). After half a dozen similar reminders from various staff members (e.g. “the meds will control your symptoms, but they’ll never cure you”), Olivia began to wonder about the assumptions that underlay their predictions:

It’s one thing if they’re like, ‘Take this, we think it’s good for you.’ But, it’s literally, they were like, ‘We know for sure you’ll never be okay again.’ How can you know for sure? … Then, literally the night before [being discharged], shrink man comes up and goes, ‘We don’t want to set you up for disappointment. Happy endings aren’t like this ((snaps fingers)). It doesn’t work like that for mental health.’ … All of a sudden, it was like, he was like—it was like he was saying, ‘You’ll never be healthy without my say so.’ That was when it hit me. ‘Dipshit. If I wanted this, I could’ve stayed with Greg.’

After her release, Olivia continued to take her medications at the prescribed intervals for about three weeks. At this time, she moved in with a friend (“one of the only ones left”), whom she stressed constituted her entire support network during this difficult period. One night, Olivia awoke at around three o’clock and, wearing only a t-shirt and flannel pants, walked out of the house, made her way to a nearby public park and lay down on a bench. About half an hour later, Olivia’s worried friend discovered her on the bench, staring into the night sky and whispering angrily to herself about her life, her shattered hopes, and all of the things that had seemingly gone wrong during that one, awful year. When Olivia first shared this story with me, I tensed at this juncture, expecting the narrative to conclude with the friend calling emergency services and relinquishing Olivia into psychiatric custody. Instead, her friend forced Olivia onto her feet, walked her home, and sat her down on a sofa with a warm blanket. Her friend then heated a frozen dinner in the microwave, made Olivia eat it (“kind of gross, but it was hot”), and sat up with her until the sun began to rise, listening to her outpourings of grief and disheartenment (“she didn’t get [understand] a word, but she stayed”). A pivotal exchange occurred during this night. Olivia had confided to her friend that she was beginning to believe what her psychiatrist had said to her, that she feared that she had been made permanently “crazy,” and that the stable, contented life that she had led prior to her first hospitalization was irretrievably lost. The friend, whom in hindsight Olivia speculated must have been bored or exhausted by her nocturnal soliloquy at this point, simply replied, “If you don’t want to take the drugs, don’t take the drugs.”

Abruptly quitting psychopharmaceuticals when one’s body has become acclimated to them is considered extremely dangerous within both the biomedical and psychiatric survivor communities, due to the ferocious withdrawal symptoms that can result (Maddock and Maddock
2006). Even healthcare professionals who discourage the use of psychopharmaceuticals stress that discontinuation should be attempted only under medical supervision, and undertaken in gradual 10% decrements (Breggin and Cohen 1999). As was repeatedly pointed out to me during my fieldwork, the difficulty of tapering off of psychiatric drugs is compounded by the fact that few doctors are willing to supervise the process for reasons of liability. Olivia’s friend was not a psychiatric survivor, nor did she have any firsthand experience on psychotropic medications, nor did she profess or possess any expert knowledge on the topic of withdrawing from them. According to Olivia, it was precisely this ignorance about the risks of sudden cessation—on both of their parts—that made her friend’s blasé dismissal of the need to comply with prescribed treatments seem reasonable, achievable, and unproblematic. Motivated by a combination of factors—the outrage and pain elicited by the paternalistic lectures she had received as an inpatient, her friend’s nonchalant suggestion, and, crucially, her friend’s compassionate provision of food and shelter at a time when she could secure neither for herself—Olivia decided to wean herself off of her medications (“I wanted a normal life again”). For weeks, Olivia stayed home and spent much of her time in bed. She had no place to go, as she had been terminated from her job, although she allowed her friend access to her pre-hospitalization savings to offset living expenses. Olivia began to space out her dosages of Risperdal (risperidone, an atypical antipsychotic commonly prescribed for Bipolar Disorder), Xanax (alprazolam, a benzodiazepine used to treat anxiety), and Zoloft (sertraline hydrochloride, an SSRI antidepressant) in slow, successive increments: instead of ingesting a full dosage each day, she took two dosages every three days, then three every seven days, and so on. Withdrawal symptoms set in immediately.

When you’re on, like, two or three or four drugs, and then you want to stop, there’s no clinical trial that’s done for you—like, to figure out what is going to happen to you in different cases. The trial is you. Whatever you go through, you’re on your own, like, in terms of figuring out why you’re wasted—like you want to sleep, but you’re too panicked to sleep, uh, your heart is pounding, you’re, like this ((imitates

97 One MD with whom I spoke specifically cited the case of Torontonian fitness educator David Carmichael who entered a state of psychosis while attempting to wean himself off the SSRI antidepressant Paxil in 2004, and whose case will be discussed in the next chapter. On his own initiative, Carmichael first ceased taking Paxil altogether for several days, then began taking it again to mitigate withdrawal symptoms, and then increased his daily intake to 150% of the prescribed dosage. Within days, Carmichael became suicidal and then homicidal; he killed his 11 year-old son shortly thereafter (Janson 2007). In 2005, Carmichael was deemed “not criminally responsible” for the act, and in 2009 he received an absolute discharge from the Ontario Review board (Henderson 2010), a judgement that remains controversial within the Toronto psychiatric survivor community (see chapter 7). This MD, who was not involved in the Carmichael case, noted that it is impossible to know exactly what role Paxil played in this tragedy, and it is thus impossible to know whether or not medical supervision of the withdrawal process would have prevented it. Accordingly, while Breggin and Cohen—respectively, a psychiatrist and a psychologist—advise patients to withdraw from medications only with professional assistance, they acknowledge that “most people who come off psychiatric drugs have successfully done so on their own, without active clinical supervision” (1999: 113, emphasis in original) due in part to the dearth of professionals comfortable with assuming responsibility for potentially untoward outcomes.
After seven challenging weeks of chaotic symptomatology, Olivia’s body and consciousness began to regain a sort of equilibrium. She began to feel like “a normal person” again, and was able to awaken each morning without being immediately seized with nausea and churning feelings of dread. She regained the ability to make it through the day without feeling the urge to cry, and reclaimed her “clearness of mind,” which she described as the capacity to alight her thoughts on any topic whatsoever (“let’s say, a chair”) without having to rein in uncontrollable visions of possible calamities and worst case scenarios (“you sit, it crumbles, and your thigh gets speared on the part of the leg that’s splintered”). Toward the end of week eight, she ingested half of a Xanax tablet then flushed all of her remaining pills down the toilet. She then cleaned her friend’s apartment, stocked the refrigerator with groceries, and began updating her résumé, determined to put the lie to her clinicians’ predictions. That terminal half-tablet of Xanax was the last contact Olivia ever had with psychiatry.

Olivia’s story of “treatment non-compliance” exhibits a number of interesting features. In some respects, her friend’s interventions mirror those of her clinicians: she forcibly prevents Olivia from following through on actions she deems undesirable (spending the night on a park bench), feeds her unpalatable food (a pre-packaged microwave dinner), and is uncomprehending of her existential difficulties (“she didn’t get a word”). However, it is clear that the friend played a crucial role in Olivia’s life during the delicate period following her second hospital stay, by furnishing her with not just housing but hope. By walking Olivia back home and staying up till dawn to listen to an anguished monologue that may not have been fully intelligible to her, the friend provided Olivia with a space of non-judgemental ratification that stood in stark contrast to the highly judgemental spaces she navigated while living with Greg and under psychiatric supervision. By not instinctively interpreting Olivia’s strange behaviour as evidence of relapse and seeking out expert help to quash the underlying “illness,” the friend gave Olivia an opportunity to air her grievances in the presence of an equal, rather than in the presence of authorities whose potential responses (e.g. assigning more diagnoses, prescribing more
treatments, taking away inpatient privileges) would constantly have to be gauged and negotiated during any attempt to emotionally ventilate. Although Olivia credited her friend with the initial idea to be treatment non-compliant, it is the way in which the idea was advanced—insouciantly and in ignorance of the potential risks—that made permanent liberation from psychiatry seem suddenly within reach. In short, her friend’s casual deprioritization of institutional expertise at every major juncture during this episode slowly and subtly nudged Olivia herself into the role of “expert,” such that her later decision to taper off of her medications no longer seemed so forbidding.

It is also noteworthy that Olivia’s desired endpoint was to live “a normal life again,” a status that had been destabilized by her pharmaceutical treatment regimen. People who identify with anti-psychiatric ideologies are sometimes accused of denying the legitimacy (or existence) of crushing psychological pain or of philosophical torments that make it impossible, or at least intensely challenging, for distressed and disoriented people to function “normally” in civil society (Szmigiero 2009). I want to emphasize here that it is the false dichotomy between illness and weakness that gives rise to these accusations: if excruciating psychic distress is only either a somatic pathology or a personal deficiency, then surely a “moral vision that treats the body as choiceless and nonresponsible” is the more humane of the two (Luhrmann 2001: 8). However, the dichotomy begins to fray when we take into consideration the fact that excruciating distress is a natural response—neither sick nor weak—to onerous conditions and humiliating circumstances. Olivia’s desire to become “a normal person” does not signal her capitulation to the somatically normative logic of biological psychiatry; it signals her desire to lead a certain kind of life, to live with the autonomy and dignity that she enjoyed prior to being diagnosed and prescribed chemical prostheses that “will control your symptoms but… never cure you.” My objective here is not to argue that Olivia’s solution to her problem—to liberate herself of the chemicals, prove her clinicians wrong, and never again return to the psychiatric purview—can or does work for all psychiatrized people. I want only to stress that the causes a person attributes to their pain will have clear implications for what route to “recovery” makes sense to them.

What is the significance of Olivia’s story to current theorizations of “recovery” in mainstream psychiatry? This question must be understood in the cultural frames that situate patients as just one category of stakeholder in the broader psychiatric economy. In chapter 3, I reviewed some of the developments that have facilitated the rise of a multibillion dollar psychopharmaceutical industry in a market economy that obliges publicly traded companies to maximize profits. Of particular importance in that historical narrative was the development of the
“disease specific” DSM-III, and all subsequent editions, which over the past thirty years has provided prescribers, insurers, and researchers with a clearly codified slate of “mental disorders” that can be leveraged to secure insurance remittances or justify the innovation of new drugs. Andrew Lakoff (2008) has pointed out that, under regulatory norms that require pharmaceutical firms to design compounds that “target” specific diseases, psychopharmaceutical developers face unique challenges: because their disease “targets” lack clearly defined biomarkers (i.e. no reliable biological tests exist for any mental illnesses, see Singh and Rose 2009, Tucker 1998), researchers cannot tailor their compounds to the diseases. Thus, in a reversed fashion, an “illness comes gradually to be defined in terms of the intervention to which it ‘responds’” (Lakoff 2008: 744), such that whatever responds to an antipsychotic may be conceptualized as psychosis, and whatever is dampened by an anxiolytic as anxiety (see also Owen et al. 2007). To understand this development, we must remember that modern regulations require all marketable pharmaceuticals to demonstrate efficacy on specific diseases in randomized, controlled clinical trials, and drug manufacturers are thus obliged to link their compounds to particular, named diagnoses (chapter 3). The DSM-III’s new slate of codifications represented a convenient solution to these regulatory pressures: it facilitated the identification of testable (diagnosed) bodies for the legally required clinical trials, offered flexible answers to questions about approved and unapproved uses (e.g. a drug may be approved for major depression but not for dysthymic depression, reinforcing an image of specificity even though the two conditions are not neatly distinguishable), and furnished researchers, regulators, prescribers, insurers, and users with a shared language of disease targetability. In the face of the DSM’s conceptual malleability—not everyone with the same diagnosis exhibits an identical set of symptoms—and in the face of their continued failure to find biological markers for psychiatric syndromes, mental health researchers have been able to strengthen their credibility by establishing drugs as not just rehabilitative but definitive of targeted diseases, and have, in so doing, gained access to the rich vein of personalized drug therapy (i.e. in which individuals are “classified according to their likely response to a medicine” and assigned diagnoses based on their response profiles; Roses 2000: 860; see also Foster et al. 2007, Porcelli et al. 2011). In short, for pharmaceutical firms, governmental regulators, health insurers, clinical researchers, and other institutional stakeholders, “it is the drug, rather than the depressed patient, that serves as a stable reference point,” cleaving the ill from the healthy (Lakoff 2008: 749). Thus, the logic of targeted chemical intervention is increasingly corroborated and justified in a tautological manner: it is “being made more accurate, not by finding the perfect pharmacological key to fit the illness but by changing
the very nature of the lock into one that, by definition, matched the key” (Lakoff 2008: 755; emphasis in original).98 “Mentally ill” bodies with a diagnostic label come to be seen as clearly defined receptacles for drugs with standardized dosages and predictable effects (Lakoff 2005, 2008; Schlosser and Ninneman 2012; see also Healy 1997). Within this paradigm, to eschew the “accuracy” of modern pharmacotherapy is to eschew scientific progress, and may even be to exacerbate others’ suspicions that one is less than rational.

When psychiatric patients enter the mental healthcare system, whether voluntarily or involuntarily, they enter an infrastructure of financial interests, technological innovations, and commercialized knowledge hierarchies that are authorized to act upon their bodies. Although psychiatry’s embeddedness in commercial agendas is not unique in medicine, psychiatric patients’ “lack of insight” has attracted an inordinate amount of attention from industry, as it is among the most reliable predictors of treatment non-compliance and, thus, profit loss. Marketer-turned-anthropologist Kalman Applbaum (2009: 111) has noted that there is an emerging “consensus among financial stakeholders involved in the provision of the medicines themselves—pharmacists, insurers, and drug manufacturers—that non-compliance… is responsible for a sizeable dent to their bottom line.” In a company newsletter, the pharmaceutical multinational AstraZeneca complained that, “The direct costs of noncompliance with antipsychotic medications range from 10 to over 50 billion dollars a year” (quoted in Applbaum 2009: 111). One company manager told Applbaum, “When a patient doesn’t take [his or her] meds on a given day, that’s a lost sale” (2009: 114). And, as the tagline for a corporate-sponsored Compliance conference (October 2006, Philadelphia) put it, “Take a $1 billion dollar product: even a 5% increase in patient compliance can trigger as much as $40 million in additional income” (Applbaum 2009: 118). Clearly, pharmaceutical firms are strongly incentivized to promote treatment compliance, so as to stem the diminishing return on investment represented by prescriptions that are never filled. Promotion techniques have thus included “compliance packaging” (e.g. dosage calendars and child-friendly starter kits that “drive up the cost of the drugs… but improve compliance and therefore contribute to overall profitability of the brand,” Applbaum 2009: 123); personalized telephone calls to consumers; educational partnerships with doctors, medical councils, and charitable groups; and anti-stigma

98 Lakoff (2008: 755) speculates that diagnostic questions devised under this emerging prioritization of medication response may eventually no longer ask, “Is it bipolar disorder or schizophrenia?” but rather, “Is it a lithium or an olanzapine response profile?” Yet, as Lakoff points out, because medications have multiple somatic effects (only some of which constitute the intended therapy), a drug’s capacity to allay symptoms in a specific person does not necessarily mean the drug is successfully acting upon a specific illness entity (2008: 748).
campaigns that cast a positive light on both illnesses and medications, but that in the long run also contribute to the expansion of psychiatry’s jurisdiction in daily life (Applbaum 2009: 117-118; see also Conrad and Leiter 2004, Petryna and Kleinman 2006, Smardon 2008).

It is noteworthy that non-pharmaceutical therapies (e.g. nutrition, exercise, counselling, art therapy) do not fall within the purview of “compliance” programs that are meant to shepherd patients along the road to “recovery,” and, indeed, such therapies are largely irrelevant to the logic of targeted biochemical intervention. Therapies that lack commercial applications tend also to lack the affluent sponsors whose efforts (marketing, lobbying, etc) play a major role in determining which treatments do and do not get endorsed in public healthcare systems and disability support programs, in private insurance policies, and in medical conferences and curricula (Shumka and Benoit 2007, Schlosser and Ninneman 2012, Whooley 2010). It must be borne in mind that alternative therapies are not innocent of commercial interests, and that the logic of holistic health—no less than the logic of pharmacological health—“runs the risk of becoming a subtle moral crusade which equates specific lifestyles with moral failures and in essence depoliticises the social origins of disease by blaming the victim” (Baer et al. 1998: 1499-1500; see also Bell 2010, Nelson and Macias 2008). Nonetheless, as will be discussed below, alternative pathways to health can play a major role in emancipating people from psychiatric technologies they see as unacceptably intrusive, and it is precisely for this reason that pharmaceutical industrialists must marginalize them:

Whatever outlook industry marketers might have toward the goal of providing health benefits for their consumers, their product largely determines the means by which this goal is to be achieved: pills are the cure, the more the better. With the growth in the maintenance drug market, pills are increasingly also seen as the means of prevention. Conditions that cannot be cured, but must be managed are welcomed by industry since they increase the lifetime value of the consumer. … When successful, efforts by marketers will improve compliance to drug regimes, even as this improvement may severely impede the pathway to new discovery in psychiatric treatments, and shrink the autonomy of both psychiatrists and their patients (Applbaum 2009: 124, 126; emphasis mine).

I suggested above that the goal of eliciting “good insight” in patients can become an overriding goal unto itself, which can result in the ritualization of patient/clinician interactions and diminish mutually honest engagement. In the next sections, I will argue that the goal of enforcing “treatment compliance” at all costs can also end up becoming an overriding endpoint, which can actually undermine or sabotage patients’ access to other determinants of good health. Within the biological specificity paradigm, the chief determinant of “mental health” is adherence to the pharmacological treatment plan. Other considerations, such as access to affordable housing, information, education, employment, physical safety, and the bonds of friendship—even when the patient herself sees these as urgent priorities—are secondary to “treatment compliance,”
because they are seen as outcomes rather than causes of a patient’s rehabilitation (Deegan 2007; Piat 2009; see also Barrett 1988: 291-292). “Recovery” is thus defined as a linear pathway from acknowledgement (“insight”) to successful management (“treatment compliance”) of one’s mental illness, accomplishable only with the intervention of doctors and other expert stakeholders. That is, one must embrace medicalization and then medication in order to achieve a lasting “recovery”—defined as the chemically maintained “remission” of illness, rather than the state of being “free of illness” (Morrison 2005: 5). Thus, as in the below excerpt from the *Journal of Psychosocial Nursing*, even “full recovery” comes to be seen as a pharmacological achievement, sustained by compliance, potentially sabotaged by non-compliance, and firmly situated in the clinical purview as merely another “phase of treatment.”

Hopelessness, poor insight, denial, delusional thinking, or cognitive impairment may be aspects of the illness, especially in severe mental disorders, that affect patients’ ability or willingness to take medication reliably (Cooper, Moisan, & Gregoire, 2007; Cotrell, Wild, & Bader, 2006; Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2002; Sajatovic, Valenstein, Blow, Ganoczy, & Ignacio, 2007). On the other hand, when patients are feeling better, especially if they are fully recovered, they may stop taking medication or not take it reliably because they do not think it is necessary anymore. … Clinicians need to understand that medication adherence is a potential problem for any patient during any phase of treatment (Howland 2007: 17; emphasis mine).

The wholesale assimilation of “recovery” into a school of thought that insists on the essential incurability—but potential manageability—of serious mental illnesses is starkly illustrated by a type of reasoning that Luhrmann (2007: 140) repeatedly heard during her fieldwork in American psychiatric hospitals:

These days, many psychiatrists will respond to the news that a person with schizophrenia can get better with the comment that if a person gets better, he or she didn’t have schizophrenia in the first place. And psychiatrists have said this to me repeatedly, despite the data stating that a third of patients with schizophrenia lead relatively normal lives.

Given the currency of this conception of “recovery,” it is unsurprising that the medical mainstream gives short shrift to the views and experiences of people who do not embark upon the insight-compliance-recovery pathway—because they find their prescribed treatments injurious and/or humiliating, or because they resent having to pass an ideological litmus test (agreeing that they have a mental illness) for their grievances to be taken seriously or to gain access to social services. It is also unsurprising that people whose firsthand experiences have

---

A revealing example is described in a May 2011 *New Yorker* article about a woman named Linda Bishop, who had been diagnosed with a psychotic disorder and had a long history of resisting medical advice. During a hospitalization, Bishop complained about being homeless, but “didn’t authorize the hospital to share her records with a free transitional-housing service, because when she reviewed the paperwork she saw her diagnosis. ‘I refuse to sign anything that says I am mentally ill,’ she told her social worker” (Aviv 2011: para. 34; emphasis mine). She ultimately died of starvation after living in an abandoned farmhouse for three months. The article was written in a manner suggesting that Bishop’s refusal to accept an illness label led ineluctably to her death. However, the
led them to define “recovery” in a contrary fashion—as liberation from rather than integration into psychiatric reasoning—may find themselves trivialized and silenced as anti-psychiatric militants and radicals when they themselves do not necessarily self-identify thus.

The 1990s have sometimes been called “The Decade of Recovery,” partly to reflect the optimistic atmosphere surrounding the publication of the DSM-III-TR and concurrent release of a new generation of psychotherapeutics (e.g. Prozac) in the late 1980s (see Anthony 2000, Clarke and Gawley 2009). Public contestations over the meanings and modalities of “recovery” thus have a relatively short history, although prominent psychiatric survivor groups have in recent years sought to problematize medicalized definitions. For example, the NGO MindFreedom International, which advocates for the rights of individuals with psychiatric diagnoses, has challenged the notion that psychiatricized people “suffer from irreversible genetic and biochemical abnormalities” by pointing out that it “promotes the idea that people are broken for life” (MindFreedom International N.d.b: para. 6; MindFreedom International N.d.c: para. 4). MindFreedom also publishes a pamphlet containing a list of “common myths about mental and emotional problems,” most of which allude to the medicalized recovery model (e.g. “myths… When people who have been diagnosed with a serious mental illness refuse medications, it is because they lack insight into their illness… Because of your diagnosis, you will always have to take psychiatric medications… If you really want to be healthy, you will take whatever medication your prescriber suggests, for the rest of your life,” MindFreedom International 2009: para. 8, 9, 11; see Figure 6.2 in Appendix II). In the winter 2009/2010 MindFreedom Journal, one writer asserted,

> The biomedical model takes away hope and responsibility: if it’s all about brain chemicals and is genetically determined, there is no hope of improving one’s life, and no reason to accept responsibility for one’s actions (Hogan 2009/10: 9).

The uneasy pairing of “hope and responsibility” is a theme that surfaces repeatedly in psychiatric survivors’ stories of achieved recovery (cf. Alyssa’s), many of which are oriented around the idea that denying illness is, in fact, the most responsible course of action that a psychiatricized possibility that Bishop may have consented to sharing her file with the housing service under a system that did not prioritize or necessitate a psychiatric label remains an open question. Indeed, given that many homeless people understandably reject labels coding them as “weak,” “crazy,” and “incompetent”—in their own eyes and those of street predators—Tanya Luhrmann (2008: 19) has recommended that “in extending offers of help to those on the street with psychotic illness, every effort should be made to avoid an explicit psychiatric diagnosis” (see also Carr 2011: 233 for a list of studies documenting the unintended outcomes of making transitional housing contingent on treatment compliance). It is also worth noting that Bishop’s continued detention in an inpatient facility may not have prevented her premature death, given that conventional antipsychotics have been linked with a threefold increase in the risk of cardiac death (Straus et al. 2004; see also Ray et al. 2001, Reilly et al. 2002, Windfuhr et al. 2011).
person can take. For instance, when long-time anti-psychiatry activist Irit Shimrat was first diagnosed with schizophrenia, she was told that “I’d always had it, and there was no cure,” and that she would have to be on antipsychotics “for the rest of my life” (1997: 20). Shortly afterward, she was transferred from a Toronto hospital to a psychiatric facility in Maryland, from which she eventually escaped: she walked off the hospital grounds after hoarding her allowance money for weeks, took a taxi to a bus station, took a bus back to Toronto, and never returned to the psychiatric system (Shimrat 1997: 26; to this day, she proudly describes herself as an “escaped lunatic”). On the basis of her own experience and interviews with other survivors, Shimrat concludes:

> What you are told about yourself has a huge impact on what you do, and how and who you are. Year upon year of hearing yourself described by a medical label can cause you to see yourself as a walking disease. Being told that you’re weak and helpless, if you come to believe it, can make you weak and helpless. Being told that you need expert help can make you need it. … what if (like most of us) you’re diagnosed with a condition that is supposed to be treatable, like “schizophrenia” or “depression”? You’re likely to be taught to depend entirely on the psychiatric system, rather than trying to change the situation that brought you into the system. Being told that you are a consumer of mental health services can keep you in that role for life. Your identity is based on consuming those drugs and “services” (Shimrat 1997: 165-166).

A more succinct example of the way in which people can learn that “recovery” means rejection of psychopharmacological interventions is provided by “Youssef,” a man whose story was distributed during Toronto’s July 2010 Mad Pride Week in an anthology of psychiatric survivor stories published by Houselink Community Homes (a non-profit supportive housing agency based in Toronto). Youssef, who began taking SSRI and tricyclic antidepressants and benzodiazepines following his divorce, developed significantly enlarged breasts as a result of one of the tricyclic compounds. He decided to quit his medications, despite the misgivings of his psychiatrist. Youssef describes the severe withdrawal symptoms as “hellish,” involving nightmares and insomnia; he nonetheless notes that, “To me this was a trade off that I was willing to take at any cost for the sake of my health” (Youssef 2009: 35; emphasis mine). He concludes by stressing “how education and knowledge about medications are paramount in the quest for recovery” (Youssef 2009: 36). In other words, Youssef links his “health” with his discontinuation of medications, and links a highly critical stance toward medications with “the quest for recovery” in general.

Before exploring additional case studies, I want to stress two points. First, by focusing on the life experiences of individuals who, for a wide range of reasons, have come to eschew mainstream conceptions of “mental health” and “recovery,” I do not mean to impugn people who benefit from psychiatric healthcare. Neither type of experience should invalidate the other; there is no contradiction in the observation that some people are helped and others harmed by
psychiatric interventions, or that some people feel validated and others invalidated by DSM labels. Nonetheless, it remains true that the two types of experience are not equally represented in the political mainstream, which overwhelmingly paints a picture of “mental illness” sufferers as voiceless beneficiaries of psychiatric expertise (chapter 4), prefiguring the frustrations of those who, “mocking, angry, or despairing of the absence of themselves as recognizable subjects in the current neuropsychiatric renaissance,” cannot find receptive audiences for their rather different stories (Estroff 2004: 283). Against this backdrop, Alyssa’s assurance that she would never openly publicize her recovery story for fear of moral censure, and Olivia’s outrage at being repeatedly reminded that she would “never be able to live without medication,” take on a new valence. Medicalized recovery narratives should not invalidate non-medicalized ones, nor vice versa, but the greater credibility and publicity enjoyed by the former are, in practice, invalidating the latter. Put simply, the fact that people can feel better after psychiatrization has slid into a widespread belief that people should feel better after psychiatrization, and that there may be something not quite right with anyone who claims not to. Moreover, as Will Hall has pointed out, “A mental disorder diagnosis and a prescription can be a huge relief if the only other option is blaming yourself as lazy, weak, or faking it… Choosing to come off medication can then seem like the wrong message, that you don’t really need help and your suffering is not really that bad” (2007: 15; emphasis mine). That is, biopsychiatry may validate lifelong patients’ pain by linguistically and pharmaceutically reifying it, but it may also invalidate the pain of those who reject either the linguistic (diagnosis) or pharmaceutical (drugs) reifications.

Second, by highlighting the economic and epistemic relationships between prescribers, researchers, insurers, marketers, regulators, and others in the pharmaceutical economy, I am not situating myself in opposition to pharmaceutical research in general. As Lakoff (2008: 742) notes, it is the way in which differential inputs of funds and labour in the global pharmaceutical industry lead to “too much access (to lifestyle drugs in the North, for example) or too little access (to lifesaving drugs in the South)” that warrants close scrutiny. While infectious diseases that disproportionately afflict the global South remain undertreated, markets for psychotherapeutic drugs in the global North have rapidly ballooned (Petryna and Kleinman 2006). Due to the fact that marketing “does not seem an imposition to most people in a consumer society, who are accustomed to trust-generating consumer mechanisms” (Applbaum 2009: 126), and aided also by the mainstream media’s preoccupation with episodic rather than systemic vectors of ill-health, pharmaceutical firms have been able to prioritize lucrative consumer demographics and enhance shareholder value while retaining a humanitarian image. Through philanthropic initiatives like
anti-stigma and “disease awareness” campaigns, firms can in fact enlarge the pool of people who are willing to accept profitable treatments (Healy 2006: 62). Yet, as Perring (2008: 11) has noted, the industry’s insistence on marketing anaesthetics for unhappiness invites suspicion and satire, particularly when deep unhappiness can sometimes be a person’s clearest hint that there is something terribly wrong with the structure of his life. As Ryan once pointed out, “When you can’t get depressed and pissed off and crazy, how are you supposed to see how depressing and crazy-making it all is?”

3. Being a Good Patient vs. Getting Better

3.1 “How Can You Not Have Fear In Your Life?”

I was always afraid to eat around Cassidy. She once spent fifteen minutes lecturing me about the effect that wheat and dairy products were having on my mental health, and she frequently expressed annoyance that my research agenda was not primarily focused on the link between micronutrient intake and cognitive performance. I once made the mistake of bringing a sandwich to a public event that we had arranged to attend. On noticing that the sandwich contained bread and cheese, she grabbed it from me (“Don’t you listen to anything I say?”) and immediately discarded it in a nearby trash receptacle. She then shared her own lunch of sliced peppers, beets, and baby carrots with me, and, as we ate, she told me story after story of friends and coworkers who had rapidly recovered from their “mental illnesses” after following her dietary advice. Despite my eventual thirst, I decided against revealing the boxed drink I had brought with me—a processed soy beverage—in the hopes of averting any further damage to her impression of me, my faculties of judgement, or my respect for her views.

Cassidy’s absolute conviction that dietary determinants of health superseded all others (“orthomolecular medicine,” from the Greek ortho-, “straight” or “correct”) sometimes brought her into conflict with other Folie à Deux members. On one occasion, a discussion became particularly heated when Ana took issue with Cassidy’s unshakable insistence that eating disorders were caused by zinc deficiencies and were unrelated to normative gender ideologies. In response to Ana’s refusal to acknowledge the primacy of zinc, Cassidy pointed out that Ana’s tendency to denounce antidepressants for inducing weight gain in patients was premised on the notion that weight gain was axiomatically undesirable. “It’s views like yours that make girls feel bad about themselves,” she rejoined acidly (and fairly), seemingly unaware that she had just conceded that body image, and thus disordered eating, could be shaped by prevailing cultural attitudes. In contrast to the broadly socialist and feminist politics that informed Ana’s critiques of
psychiatry, Cassidy’s opposition to psychiatry was grounded in the contention that psychiatric medications were, in essence, neurotoxins. She identified very strongly with the term “anti-psychiatry,” and when I first met her, I had assumed that she—like most of my key informants at that time—viewed psychiatric diagnoses as historical artifacts that revealed more about social prejudices than biological pathologies. I was disabused of this notion during an incident that opened my eyes to the ideologically heterogeneous nature of “anti-psychiatry” as worldview and identity. After one of my first Folie à Deux meetings, Cassidy took me aside and requested politely but sternly that I never again bring bagels for the group to snack on. Gluten (a protein composite found in wheat, rye, and barley products) was a “major cause of mental illness” and the “only cause of depression in lots of people,” she told me. “Ana wants to bake. Let her bake. You’re an academic—shouldn’t you know better?” Taken somewhat by surprise, I asked if I had misunderstood her attribution of causality. Did she just say that gluten was often the sole cause of depression? Wouldn’t that make depression an almost strictly biochemical disease? Cassidy was incredulous at my naiveté:

It’s all biochemical. I just shudder when I hear young people talking like this. Get your head out of the social construction ghetto.

Cassidy’s own disavowal of constructivist reasoning was somewhat less complete than this enjoiner might suggest. Following a failed relationship in the early 1990s, she began experiencing panic attacks and crying spells while performing previously unproblematic tasks, like placing telephone calls and navigating the public transit system. She asked her GP to refer her to a psychiatrist. Within half an hour of her first appointment with the psychiatrist, she received a diagnosis of clinical depression and a prescription for the antidepressant Prozac (fluoxetine), which had only been on the market since December 1987 (Shorter 1997: 323) but would come to account for 32% of its manufacturer’s total sales by 1996 (Lewis 2006a: 135). Cassidy dutifully took her daily dosage, and within days found that she no longer felt dysphoric or fatigued—in fact, she felt almost nothing at all. She became, in her words, “emotionally devoid.” Although she had always kept a daily journal, she soon lost the motivation to write new entries (“You can’t write when there’s nothing that bothers you”). Her ex-partner’s departure from their once shared apartment meant that Cassidy was now unable to afford the rent without dipping into her long-term savings; nonetheless, because she felt no anxiety about the matter, she felt no pressing need to search for a more affordable place or to budget her financial resources more strictly. When her sister called to chat about personal problems, she knew “rationally” to respond with pronouncements of sympathy, but she said that she felt no sympathy for her sister’s
travails. However, because she forced herself to produce socially appropriate responses when interacting with others, her diminished emotional repertoire escaped the attention of her psychiatrist, friends, and family. Cassidy was mildly uneasy with her loss of interest in writing: her journal now went untouched for several weeks at a time, and new entries tended to consist of just a few half-hearted sentences. She became seriously concerned only after discovering how dire her financial situation had become, a little under a year after starting Prozac.

I just stared at the little slip [referring to an ATM’s printed statement of the balance in her savings account]. The number was half what it was before I got on [Prozac]. Well, I should be embarrassed—and in my mind, yes, I knew to be embarrassed. [But] I felt no worry, wasn’t alarmed at all. It was very much, ((mimicking feigned interest in the ATM slip)) ‘Huh, isn’t that something.’

Disconcerted by her failure to react with instinctive alarm to an alarming situation, Cassidy resolved to bring her emotional limitations to her psychiatrist’s attention. At her next scheduled appointment, she related her theory that the Prozac was impairing her judgement and thereby endangering her (“You know, it’s like, ‘Well, wait a minute. How can you not have fear in your life? Isn’t fear what tells you something’s wrong?’”). Her psychiatrist warned her that the unavoidable outcome of drug discontinuation would be “a relapse.” He reminded her of how well she had felt after first taking it, and encouraged her to stick to the treatment and to return to see him in four months. As Cassidy sat, listening patiently, it slowly dawned on her what had to be done. She politely agreed to his recommendation, pocketed the new prescription he had written for her, and booked the follow-up appointment with his receptionist. She then left the premises as quickly as possible, and never returned.

You see, I had been asking myself all along, ‘Which is the real me?’ Ninety-nine percent of my life, I was this person. A little bit of fluoxetine later, I became that person. … Eleven months of nothing [emotionally], and then—bang—fury [following her appointment with the psychiatrist]. It was truly for once in eleven months that the real Cassidy was getting through. … It’s like this. It chokes up your receptors. It blocks transmitters that your body wants to send. When you have honest feelings they [the neurotransmitters] can’t plug in. You’re in a chemical straitjacket.

Cassidy immediately ceased taking Prozac. Over a six week period, she experienced headaches, heart palpitations and insomnia as her body adjusted to the change, and emotional highs and lows eventually came surging back into her life. In one of her first lengthy journal entries after coming off of Prozac, she wrote out a ten point plan for getting her life “back on track.” She scoured classified ads, found a more affordable apartment, and made arrangements to move in as soon as her current lease expired. She then converted a portion of her remaining savings into money orders made out to her new landlord, so that she could never be tempted to spend it on anything less essential than shelter. “It felt good, you know, to work out those steps,” she said. “A lot of times, just starting and ending a task—it tells you, you’re not broken, you’re capable of much
more.” However, a more significant turning point occurred when, during one of their regular telephone chats, Cassidy’s sister became infuriated with her disagreement on a particular issue.

She said, ‘You were a much better friend when you were on Prozac.’ She said this to me, which in essence—that is very painful to deal with. Because when you’re void of emotion, yes, in some ways you are a better friend. Just the notion of making up for feeling nothing by acting proper, as pleasant as the situation dictates. … ‘I don’t want you, I want the Stepford sister back,’ was what she was saying, in essence. … and sometimes even now she’ll start. “You were such a nice person to be around [when you were on Prozac].” What can you say to that?

Cassidy indeed did not know how to respond to this critique, so she simply apologized for being inadequately supportive and did not challenge the remark. However, in the weeks and months following this incident, she began reading everything that she could about depression, antidepressants, and mental health in general, “to prove the problem wasn’t me.” She spent entire weekends in public libraries, and borrowed “big bags of books” to work through on weekday nights. In the back of a book whose title she remembered as *Canadian Law and Psychiatry*, Cassidy found a short history of the anti-psychiatry movements of the 1970s and 1980s. She became excited at the thought that there were others who had felt more harmed than helped by psychiatry, and she began following up on the footnotes, many of which made reference to *Phoenix Rising* essays and the Toronto psychiatric ex-patients’ group, On Our Own. Cassidy made contact with On Our Own and met with a member, who, instead of giving her a copy of *Phoenix Rising* (as she had requested), gave her a back issue of a newsletter called *Dendron*, which was published by an American organization called the Support Coalition International, and which contained a number of essays about patients’ adverse experiences on medications.

The second I saw these people even existed, I felt ten thousand times better. It was just one of those magic moments, where all of a sudden (gasp) ‘It’s not me. It’s a whole bunch of people.’

Cassidy did not credit *Dendron* with her interest in the dietary determinants of mental health. In the course of her research, she discovered writings by the Canadian biochemist and physician Abram Hoffer and the British psychiatrist Humphry Osmond, both of whom claimed to have cured thousands of schizophrenic patients beginning in the 1950s by administering large doses of niacin (vitamin B3). She also discovered that in 1968 the American chemist and double Nobel laureate Linus Pauling had authored a controversial *Science* paper about the efficacy of

---

100 I believe that Cassidy is in fact referring to a book called *Mental Health Law in Canada*, which exhibits all of the traits she describes: a brief section entitled “The Antipsychiatry Movement” that is located at the end of the book, and footnotes that refer to *Phoenix Rising* and On Our Own. This book was published in 1987 by Butterworths Canada; it was co-authored by Harvey Savage and *Phoenix Rising* co-founder Carla McKague (see chapter 3).

101 This group was the direct antecedent of MindFreedom International. Support Coalition International was founded in New York City in May 1990 by activists protesting the 143rd meeting of the American Psychiatric Association.
vitamin therapy in psychiatry, and that Pauling eventually became a prominent advocate of the idea that large doses of vitamin C could prevent cancer and the common cold. While she did not accept these claims wholesale, the notion that mental and physical health were coterminous struck her as eminently reasonable. As she often told me, as part of her ongoing project to rehabilitate my dietary choices, “When you’re depressed, the problem isn’t here [touches her head], it’s here [indicates her whole body with a sweeping hand motion].”

Cassidy continued to read voraciously on the topic, and uncovered an eclectic variety of theories about the therapeutic effects of vitamin and mineral supplementation on conditions as disparate as acne, allergies, autism, depression, hypertension, and mononucleosis. In the late 1990s, when she began experiencing crying spells and panic attacks again, she put her new knowledge to work. She radically altered her diet by eliminating gluten, refined sugars, caffeine, and lactose; her mood stabilized, and she became convinced of the facticity of orthomolecular principles. Her periodic disputes with Ana have served only to reinforce her convictions:

Yes, we were at a food festival [describing her first encounter with Ana]. We got to chatting, and about anti-psychiatry, she said she’d known survivors in San Francisco with tardive dyskinesia who’d wanted to get tricyclics and clozapine banned. Well, yes, and—? Look, they wake up and it’s coffee and doughnuts. Why should it be a surprise? The revolving door. They’ve got to get off these toxins, the sugar, the fat, the gluten. But, you’ve seen her—to this day, she rolls her eyes.

* * *

In 2004, psychiatrist Nanette Gartrell authored an essay in the *New York Times* about her experiences on the antidepressant bupropion (commercially better known as Wellbutrin, Voxra, or Zyban, although she does not name any brands). Within ten days on bupropion, Gartrell began experiencing tremors, panic attacks, and paranoid delusions, and “lost the ability to distinguish between sadness and the drug’s side effects” (2004: para. 3). Gartrell discussed the matter with other psychiatrists, but was unable to determine what was happening to her. She was finally put in touch with a journalist and former cocaine user who had experienced similar adverse effects while on bupropion; he told her that using bupropion felt “like coming off a coke high, that he would choose grief any day over bupropion” (2004: para. 6). Gartrell decided to wean herself off the medication, and, shortly afterward, the adverse effects dissipated. She concluded the essay by pointing out,

If finding useful information was so difficult even for a physician like me, how do most people with antidepressant toxicity fare? In my case, a former cocaine user was more helpful than books, journals or even colleagues (Gartrell 2004: para. 7).
Disclosures such as these appear only sporadically in the mainstream news media, although news reportage can become more critical about the ubiquity of psychopharmaceuticals when focusing on scandals that implicate large pharmaceutical firms (e.g. Eli Lilly’s misrepresentation of Zyprexa’s metabolic risks). Because the mainstream media overwhelmingly prohibit “mentally ill” people from speaking for and about themselves in reportage on “mental illness” (see chapter 4), it is unsurprising that “people with antidepressant toxicity” are frequently unable to learn about each other’s experiences or to access information about alternative approaches to mental health, unless they have the time and inclination to engage in long-term research projects. For Cassidy—who did indeed have the time to do this—it was precisely “books, journals, or even colleagues” that facilitated her discovery that numerous other patients had responded poorly to psychotherapeutic drugs, and that nutrition was a cardinal determinant of mental wellness. I will return to the emancipative importance of access to information later; for now, I want only to draw attention to the fact that Cassidy’s access to helpful information was contingent on a constellation of factors beyond her control, such as her proximity to libraries, the diversity of these libraries’ holdings, and the fact that she did not have other obligations that would consume her nights and weekends. Moreover, the fact that Cassidy is now able to customize her diet in accordance with “orthomolecular” principles—that is, the fact that she is free to choose what she eats and what she does not—reflects her geographic privilege and her current level of financial security, given that there is substantial expense associated with purchasing nutritious foods (Bell 2010: 355, Nelson and Macias 2008). By pointing this out, I do not mean to trivialize the immense amount of time and energy that Cassidy has put into crafting a healthy life. My point is simply that her achieved recovery from both psychiatrization and depression was facilitated by social and structural determinants that, in another time or place, might have been absent. In the absence of these determinants, Cassidy’s recovery from her second depressive episode and her permanent escape from the psychiatric purview might have unfolded differently or not at all. In such a scenario, her continued suffering would be an understandable consequence of structural violence: her inability to access informational and nutritional resources would reflect neither “illness” nor “weakness.”

At the same time, it is clear from her repeated attempts to rehabilitate others’ diets that her “anti-psychiatry” includes—and does not reject—making distinctions between pathological

---

102 Indeed, despite Cassidy’s absolute confidence that dietary determinants of mental health superseded all others, she was not unaware that socio-economic factors stratified people’s access to nutritional resources. During several Folie à Deux meetings, she advocated the introduction of publicly owned community gardens in urban neighbourhoods, so that lower income residents could avail themselves of fresh produce.
and non-pathological states of mind. The “anti-” in her “anti-psychiatry” arises from a conviction that psychiatric interventions harm people’s mental health, which itself arises from her experience with Prozac and her subsequent discovery of the psychiatric survivor movement. Unlike some of my other informants, however, Cassidy did not ascribe terrorizing somatic and phenomenological side effects to her antidepressant. She found Prozac objectionable precisely because it did its job: it anaesthetized her feelings of sadness. However, by displacing a distressed consciousness with an “emotional void,” the Prozac inadvertently made it impossible for her to care enough about anything to continue writing in her journal (previously a valued part of her life) or to react to her dwindling savings with anything more than mild discomfort. For Cassidy, it was the absence of fear and anxiety from her life that became pathological and potentially life-threatening. Without negative emotions like these, she realized that she no longer had an interior warning system to motivate her into immediate action in times of urgent crisis. However, her method of compensating for her emotional limitations—acting like a sympathetic conversation partner even when feeling no sympathy—served to convince her interlocutors that the Prozac was, in fact, improving her mental health. When Cassidy later discontinued the drug, she no longer felt obligated to overcompensate for feeling “emotionally devoid” by feigning amiability, and she thereby became, from her sister’s vantage point, a worse friend.

Maddock and Maddock (2006) have pointed out that “non-compliant” psychiatric survivors can find themselves unable to reveal the truth of their experiences to friends and family who firmly believe that psychiatric treatments save people from themselves. They describe the case of a man (“Paddy”) who was put on two conventional antipsychotics (chlorpromazine, flupentixol) and a tricyclic antidepressant (dosulepin) because he experienced auditory hallucinations. Although he compliantly took the drugs for ten years, he eventually decided that their sedative effects were intolerable and weaned himself off of the treatment plan:

Apart from the group of people who helped him to come off the medication, Paddy did not tell anyone that he was coming off the drugs. Over the years he had learnt that if he did tell people (including the psychiatrist), they would insist that he continue with his medication. For three years, Paddy found himself in a bizarre situation: he was off all medication but everyone around him thought he was continuing on the drugs as usual. Paddy’s family and friends soon noticed big changes in him. They would often say that Paddy was ‘himself’ again. They marvelled at the wonders of modern medicine and in particular, Paddy’s medication which was obviously now working effectively. Everyone was talking about the miraculous improvement in Paddy’s condition. Paddy describes this as an ‘internal prison’; he wanted to tell everyone that he was off medication and doing brilliantly without drugs but he could not tell anyone for fear of being persuaded (or even forced) to go back on his medication (Maddock and Maddock 2006: 93).

My point here is not that drug discontinuation is necessarily or invariably a desirable course of action, even for patients who find their side effects objectionable; current users of
psychopharmaceuticals must discover for themselves whether their drugs are, in the specific context of their lives, “part of the solution or part of the problem” (Chamberlin 1998: 50; see also Deegan 2007). I wish only to draw attention to the fact that—contrary to much popular wisdom—psychiatric patients’ friends and family are not always the best judges of how well they are doing, either on or off their prescribed treatments. When serene, courteous behaviour is misread or even celebrated by well-intentioned onlookers as confirmatory evidence of “mental health,” it can become exceedingly difficult for former patients to find ratification for oppressive serenity experiences. Because observers have no access to a patient’s interior feelings, it is of course understandable that their judgements will be based on visible, exterior dispositions. Nonetheless, “mentally ill” people who eschew treatment may find themselves unable to deviate from their families’ preferred norms of behaviour without attracting critique or consternation: rather than being seen as independent, they may come to be seen as, essentially, lapsed patients. As Maddock and Maddock make clear, “Paddy” sought to forestall this perception by not revealing to anyone that he was off his drugs, electing instead the “internal prison” of silence. Although Cassidy did not maintain similar secrecy around her discontinuation of Prozac, she did not rebut her sister’s hurtful remark, electing instead to internalize the critique through an apology. According to her, she has in fact never directly rebutted the remark; her preferred response is to change the topic and avoid argument altogether, because, as she told me, “it’s just easier.” In short, Cassidy feels she must let her sister’s critique go uncontested and demur only through polite deferrals and withdrawals, because the interpersonal costs of doing otherwise may outweigh any potential benefits.

Cassidy’s story follows an arc that is common in psychiatric survivors’ narratives: she begins in a state of unawareness, falls prey to an untoward effect of psychiatric intervention, suspects that her treatment is doing more harm than good, and decides to extricate herself from the psychiatric purview. Nonetheless, her story is somewhat unique among the set of life stories I encountered, in the sense that her “orthomolecular” etiologies of mental illness are arguably just as deterministic as mainstream neurochemical theories. On the one hand, she is not wrong about the linkage between nutrition and the embodied texture of what our society calls “mental health”—which I would suggest is better defined as feeling well in a broad sense. There is no contradiction in acknowledging that “depression” is an understandable outcome of exhausting and desolating life circumstances, and acknowledging that the person who is experiencing “depression” is a biological organism that responds to metabolic inputs. On the other hand, the latter acknowledgement is not equivalent to the assertion that “depression” is caused by a
targetable biochemical imbalance, given that “depression” is not conceptually independent of cultural norms and, within them, personal norms. For example, Stoppard and Gammell (2003: 41) point out that it is common for women to view psychiatric “symptoms” such as fatigue and despair as entirely normal within the context of their lives, and not a cause for concern unless they become “unable to handle family or job responsibilities to their own satisfaction.” Just as it would be simplistic to assert that fear is caused by adrenaline, or that love is caused by oxytocin, it is misleading to link depression to any discrete set of chemical triggers, not least because fear, love, depression, exhaustion, anger, escapism and other phenomenological states are mediated by such a wide range of iconographies and memories that they are sometimes indistinguishable. It is in this context that Cassidy’s forceful advocacy of “orthomolecular” principles must be understood: when she insists that refined sugars, gluten, caffeine, and lactose are major causes of “depression,” she is insinuating that, by eliminating these substances from her diet, she was able to dispel the specific phenomenological status that she defined as her depression. Like Alyssa, she “can’t deny” the lessons her life has taught her. However, as we will see in chapter 7, the impossibility (or undesirability) of denying one’s own firsthand experiences can sometimes make lasting political solidarity infeasible.

3.2 “What We See, Nobody Else Does”

When I first began attending Acceptance meetings, I expected that the broad emphasis of each meeting would be on family members’ frustration with their “mentally ill” relatives. Helen, the first member I spoke to at length, stated that few others in her social circle understood what she endured on a daily basis while raising a son with an ADHD diagnosis and living with a depressed husband, and that the group had been “a godsend” for her. Likewise, Risa and Keane, whose teenage daughter suffered from a depersonalization disorder, said that they were grateful for the existence of a group of parents, plus one fiancé, who supported each other “without judging anyone else’s choices.” Armaghan, whose daughter Magda suffered from an eating disorder (see above), once asserted, “What we see, nobody else does,” in response to an anecdote

103 It is also worth noting that when ethnographers fail to question their own prejudices, psychiatric survivors’ instrumentalization of nutritional knowledge can go unrecognized. During many Unhinged meetings, Olivia would meticulously peel a single orange and then eat the interior juice vesicles. Without looking up from her sketchpad, Melinda would then reach over, collect the discarded tangle of white rinds, and slowly eat them, strand by strand. At first, I found this disturbing and slightly disgusting. A few months into my fieldwork, it was explained to me that Olivia suffered from dust allergies and that Melinda had high blood cholesterol levels. Because vitamin C is an antihistamine and citrus rinds are rich in pectin (a soluble fibre that binds to cholesterol in the intestinal tracts), their sharing oranges in this fashion made perfect sense. Had I not asked about this, it is likely that I would have continued to view Melinda’s consumption of the rinds as an idiosyncrasy or quirk, rather than as part of a broader survival strategy.
that Helen had shared about her son’s tendency to hyperventilate or erupt in angry outbursts when asked to perform household tasks. At the time, it seemed that Armaghan was highlighting the loneliness of raising children whose anguishing behaviours were not obvious to external onlookers: Helen’s son threw tantrums in front of her, but not in front of others. However, as the months passed, I began to see hidden layers in Armaghan’s remark, which seemed increasingly applicable to professionals whose moral surveillance could often exacerbate rather than alleviate parents’ stress. I also began to realize that, in addition to dealing with family members’ frustrations with unruly loved ones, Acceptance meetings placed at least as much emphasis on the frustrations of reconciling mainstream narratives about “mental illness”—the received wisdom cultivated through daily consumption of news media, educational literature, and popular culture—with firsthand experiences that did not jibe with them. In other words, what was socially invisible (“What we see,” which “nobody else does”) was not only their loved ones’ unruly behaviour, but a palpable mismatch between expert knowledge claims and what they knew to be true in their own lives. To illustrate, I provide here a few case studies. These descriptions are based on my field notes from Acceptance meetings, several additional discussions with parents, and supplementary interviews with two adult children (Magda and Winston). No minors were interviewed.

**Helen and Matt.** Helen’s son, Matt, had always been a quick learner and an imaginative child who gravitated toward leadership roles among his peers. So, it was always depressing when he brought home report cards with Cs, Ds, and Fs, and received reprimands from teachers who called him a troublemaker. Inspired by a series of articles in the *Toronto Star* on childhood behavioural disorders, Helen took Matt to their family doctor. After a long discussion about his chronic inability to focus on schoolwork, the doctor diagnosed Matt with Attention Deficit Hyperactivity Disorder (ADHD) and prescribed a controlled release psychostimulant called Concerta (methylphenidate). Matt began taking Concerta, and, sure enough, he became less disruptive and more studious. Helen and her husband even had the novel experience of listening to his teacher speak of “the new Matt” in glowing terms during a parent-teacher conference. Concerta’s stimulating properties had a dark side, however. Matt developed severe insomnia, and he became unable to get more than five or six consecutive hours of sleep per night while on the drug—and even then, Helen said, it seemed to be the kind of fitful, shallow sleep that “you’d have right after downing a pot of coffee.” He began to resent the drug, and Helen twice found the bottle of pills crammed into the bottom of their kitchen trashcan. During a follow-up appointment, Helen raised this concern with her family doctor, who urged her to establish a firm
bedtime for her son in order to stabilize his circadian rhythms. When Helen asked if it would be all right for Matt to discontinue the Concerta during summers and weekends, her doctor gently replied that the Concerta “was doing its job,” and that tinkering unnecessarily with the dosage could be dangerous (“it’d play havoc with his brain molecules”). Helen at first complied with doctor’s orders and tried her best to get Matt into bed by ten o’clock every night. Matt was resistant to being forced into bed when he was not the least bit tired, especially since his siblings were not held to set bedtimes, which had never been a convention in Helen’s household. Night after night concluded in pleas and recriminations; during one argument, a tearful Matt threw a fistful of Concerta capsules at his mother’s face. From Helen’s point of view, it seemed that she had traded her family’s internal harmony for her son’s improved attention span. Helen and her husband eventually agreed to give Matt “holidays” from Concerta during summers and winter vacations if he would agree to stick to his assigned bedtime during the school year; this agreement has somewhat ameliorated his resistance. They also decided to withhold this information from their doctor.

**Armaghan and Magda.** Armaghan always found it difficult to argue with Magda. In reaction to her parents’ pleas to “eat like a normal girl” and to refrain from exercising for hours on a daily basis, Magda had accumulated a folder of news clippings about the social repercussions of high body mass, which she would deploy during arguments as though participating in a formal debate. On one occasion, she printed an article from the research news hub ScienceDaily.com, entitled “Research Shows Women’s Weight Gain Brings Loss of Income, Job Prestige,” and marched into the family living room, waving it and declaring that her parents were sabotaging her life prospects. Within a six month period, Magda’s parents had her hospitalized twice for physically resisting their attempts to force-feed her. Although Magda at first agreed to try the medications she had been prescribed in the psychiatric ward—which were not targeted at her anorexia, but at a slew of other diagnoses she had received, such as borderline personality disorder and “major depression with psychotic features”—she eventually refused to take the drugs after deciding that their adverse effects were unbearable (“berserk thoughts of, like, every kind of carnage… I couldn’t get these urges out of my brain,” see chapter 5). During an appointment with Magda’s psychiatrist, Armaghan revealed her daughter’s aversion to the medications. He took Armaghan into a private consultation room and told her that she could not allow herself to be “manipulated,” and that it was her responsibility, as the parent, to enforce the treatment plan. He then gave her a photocopy of a 1997 *TIME* magazine article on serotonin, entitled “The Mood Molecule,” which was by that time a decade old (“he had, like this, a stack,”
she related, holding her thumb and forefinger an inch apart). He highlighted a sentence from the article ("A person’s mood is like a symphony, and serotonin is like the conductor’s baton") and told her that Magda could be “made healthy again” if she complied with her treatments. Family interactions soon became nightmarish, as Magda refused to eat in her parents’ presence, refused to take her medications, and sometimes ran away after heated screaming matches. The more her parents fought with her, the angrier and more resistant she became. “You have no clue—no clue—how bad things were,” Magda told me. Desperate to end the constant fighting, Magda began feigning treatment compliance: she would place her antidepressant and benzodiazepine tablets under her tongue, pretend to gulp them down with a sip of water, and later spit them out into a bunched up tissue that she would then discard. To deflect any suspicions, she also made a conscious effort to behave more pleasantly and sanguinely, and to eat full meals with her family at the normal dinner hour, only to regurgitate them later—in secret—a process that was more stressful than her relentless exercising had ever been. The household dynamic regained some of the serenity that had marked Magda’s pre-anorexic years. As she put it,

It was fucking twisted—like—you know?—here’s me on drugs ((mimics convulsions, distorts her facial features)) and here’s normal me ((settles down)). But they kept saying it was the other way around, right? I mean, they were like, ‘She’s a good little girl now. Thanks, doc, you’re the best!’ Do you get what I’m saying? I’m stickin my whole fucking hand down my whole throat, right, like, in the middle of the night, whatever. And, it’s like, ‘Maggie, isn’t it so lovely that life is back to normal now?’ Um, wow—yeah, maybe for you.

Magda told me that her psychiatrist seemed thrilled. When he congratulated her on her recovery, she smiled politely, shook his hand, and thanked him. It was a year and a half before Armaghan discovered that Magda had secretly exchanged one eating disorder for another. The serenity of the previous eighteen months had resulted not from targeted pharmacological interventions—the elegant rhythms of the “conductor’s baton”—but from Magda’s strenuous aversion to them, and the lengths she was willing to go to safeguard her bodily autonomy. The revelation that her daughter had been unnoticeably “mentally ill” for over a year compelled Armaghan to question the reliability of psychiatric diagnoses (“When you call my child sick—don’t call my child sick. You can’t prove it to me, that you know what you are saying. And [throws her hands up] that’s it.”). Armaghan now insists that she would never have allowed Magda to enter the psychiatric system in the first place if the drugs’ side effects had been clearly explained to her at the outset. The family is now in counselling. Magda no longer regurgitates her meals, but is still working through her anorexia.

**Elias and Winston.** Elias’s son, Winston, had always been introverted and had never had many friends. After dropping out of high school, he began to spend hours sitting in the dark and
listening to music through thick noise-cancelling headphones, emerging from his bedroom only
to eat, shower, nod curtly at his father, and work night shifts unpacking shipments of
merchandise at a local supermarket. Over time, Elias realized that Winston had actually stopped
talking altogether. He secretly consulted with Winston’s supervisor, who acknowledged that “the
boy was odd,” but who also pointed out that he had never once missed a shift. Elias did not feel
reassured. He began spending hours on the internet researching psychiatric disorders in order to
pinpoint a diagnosis that might account for his son’s withdrawn silence (some possibilities that
he had compiled in a spreadsheet at that time included “depression with melancholic features,”
“psychogenic fugue,” “dissociative identity disorder,” and “catatonic schizophrenia”). He took
out a subscription to Moods, a quarterly magazine that is editorially advised by a variety of
prominent Canadian mental health professionals (e.g. University Health Network researchers,
workplace health consultants). Eventually, he made an appointment with a psychiatrist, not for
Winston, but for himself. Elias described his concerns to the doctor, who agreed that “there was
likely an illness at work” and encouraged him to bring his son in for an evaluation. Elias then
returned home and confronted Winston about his sullenness, stating that he had arranged for him
to be psychiatrically evaluated. Winston—who was sitting in a corner of his bedroom, listening
to music through his headphones—stared flatly at his father for a few seconds, then closed his
eyes and turned his face away. He hadn’t uttered a single word to his father in almost four
months. That night, a distraught Elias began leafing through the latest Moods issue, where the
title of an article caught his eye. “The Enemy is the Brain Dysfunction, Not the Person!” it read.
The article, which was published in early 2009, urged concerned family members to be alert to
signs of mental illness and to intervene when sufferers reject offers of help. It began by calling
attention to the tendency of sufferers to have “poor insight.”

Poor insight, as it’s called by the professionals, often keeps an individual from accepting the offer of help
that could assist recovery and/or prevent some of the disasters that can accompany mental illness. Recent
research leads to the belief that denying mental illness and refusing to accept treatment are both a result of
the brain dysfunction that causes the illness itself. … Realizing that the person’s behaviour is beyond their
control—just like the other symptoms—and not a deliberate rejection of both reality and your attempts to
help can ease the urge to take it personally and blame them (and yourself). … Whatever its origin, the
resulting rejection of treatment and help is really, really difficult; it delays treatment and can disrupt and
destroy personal relationships (Campbell 2009: 17-18; see Figure 6.3 in Appendix II).

While reading this article, Elias put himself in his son’s shoes, and tried to imagine what he
might be feeling now that he realized that his father thought of him as “crazy.” “I decided right
then, no part of my son is going to be my ‘enemy.’ I will not conspire against him. … The way
he looked at me when I said [that he had arranged for Winston to be psychiatrically evaluated].
I’ll never forget it.” Elias cancelled the appointment. He decided that he would do nothing, at
least for a while. “Sometimes when you’re in a bad way, what you need is for a place to just be and just exist. Okay, give him that.”

I first met Elias in late 2009, during an Acceptance meeting at which he revealed to the group that he and his son had finally had a long, heartbreaking argument after months of impenetrable silence. Winston said that he felt he had no place in society—no education, no social skills, no friends, no career prospects, no abilities, no future—and had decided that, if he was going to be a lifelong outsider, he was going to act the part (“what’s the point of talking when no one listens to me anyway,” was Winston’s rationale for his silence, according to Elias).

Winston had felt particularly galled by events that had transpired years earlier, when he was fifteen. He had put all of his energy into passing a math class and trying to quit a self-harming habit that he had had for three years. In both cases, his efforts ultimately bore fruit: he was able to quit cutting for good, and he passed his tenth grade math class by two percentage points. Winston’s pride, however, was undercut by an inescapable awareness that his successes barely qualified as achievements in the eyes of others. Elias recounted his son’s enraged words: “To the whole fucking rest of the world, not failing is a given! Not cutting is a given!” As his classmates graduated, advanced in their jobs or educational trajectories, developed companionate relationships, and generally “moved on with their lives,” Winston’s musical escapism became all that he had: a reliable anaesthetic for the daily pain of a directionless life. When Elias responded that he would solicit professional help for his son’s self-harming habit, Winston exclaimed, “That was, like, five fucking years ago! Are you even paying attention?” Elias, on the other hand, contended that it was an excess of attentiveness that had blinded him to his son’s despair and bitterness. Over coffee with me and Helen, he noted that his determination to uncover a “miracle diagnosis” for Winston’s muteness and his persistent quest for information from everyone except for Winston himself (e.g. his boss at the supermarket, a psychiatrist, web forums, Wikipedia, magazines) were all premised on the mistaken assumption that “the boy wasn’t in control of himself, it wasn’t him inside”—an assumption that echoes key portions of Moods magazine’s call for vigilance.

During the one relatively short conversation that I had with Winston, I asked him how he had managed to quit “cutting,” in light of the notorious difficulty of quitting this particular practice (see Adler and Adler 2007, Boynton and Auerbach 2004). After a long, contemplative pause, he explained that he had inserted a razor blade between two random pages in the middle of a thick, hardcover book. Each time he felt the urge to cut, he would force himself to read more
and more of the book until he reached the nested blade. “I knew I’d never get there,” he said. “I hate reading.”

* * *

In each of the above stories, a moment arrives in which the need to ensure “treatment compliance” or to intervene with a potential “lack of insight” becomes subordinate to other priorities in ordinary people’s daily lives. By defying her doctor’s caution against giving her son occasional “holidays” from Concerta, Helen was seeking to alleviate and not exacerbate a health problem that was giving rise to unruly behaviour. By cancelling his son’s psychiatric evaluation in spite of his alarmingly impenetrable muteness, Elias was trying to avoid destroying his relationship with his son (despite Moods’ caution that delayed intervention could “disrupt and destroy” the relationship); and in the same way that Olivia’s access to space, time, and tolerance made it possible for her to recover from psychiatrization, Elias’s decision to give Winston a “place to just be and just exist” cleared the way for his eventual return to verbal communication and his stunning disclosures of the causes of his misery. By spitting out medications that gave her “berserk thoughts,” playacting a sanguine and courteous persona, and concealing her true feelings, Magda was seeking to safeguard and not sabotage her mental health. While I am not arguing that medical advice should never be followed, I do want to suggest that it is not uncommon—and not irrational—for ordinary people to eschew seemingly irreproachable advice because they know that following it will incur a level of cost that, for them, outweighs the level of benefit.

When a psychiatrized person finds that being a good patient is incompatible with feeling well, it is not irrational for him to prefer the latter. At the same time, “non-compliance” with treatments can easily be misread by well-intentioned observers, who have been taught by the surrounding episteme to blame “the brain dysfunction, not the person” for any undesirable acts or unexpected choices. Under the guidance of expert bodies of knowledge, which regard “chronic self-regulation difficulties” as a distinguishing feature of borderline personality disorder (Sansone et al. 2004: 62), and contend that ADHD “arises as a developmental failure in brain circuitry that underlies inhibition and self-control” (Barkley 1998: 67, quoted in Lakoff 2000: 163), family members can come to interpret insubordinate, delinquent, or unruly acts as involuntary “symptoms” that must be subdued. Diagnosed individuals such as Magda and Matt can find themselves held to far higher evidentiary standards than “normal” people when advancing knowledge claims of their own: Magda’s complaints of her drugs’ adverse effects are
disbelieved and dismissed as mere “manipulation,” and Matt’s complaints of insomnia are
deprioritized, since his drug is “doing its job.” As Pat Capponi (2003: 198) points out, family
members who become overly invested in a “specific diagnosis because they are relieved to have
an explanation for all the strange and scary behaviour” can end up typecasting their “mentally
ill” loved one as invariably less-than-whole without their chemical prostheses:

They certainly overinvest in the prescribed treatment, which is usually medication of one sort or another. It
seems clear-cut: a mental illness needs a pill or injection to control it. Why won’t the “patient” accept it? …
In facing the disease together, there cannot be equality if one partner sees him- or herself as caregiver and
the other feels constantly watched for signs and symptoms. Normal mood swings become suspect and
worrisome; we can feel at times as if we’re seen as more like a disease on the verge of an outbreak than a
person capable of the full range of human emotions. Parents and partners should not become dispensing
pharmacists who ask, “Are you taking your medications?” This question can become a great irritant and the
ground for constant battles—a test of understanding, obligation, and personality over pathology (Capponi

It is noteworthy that actual psychiatric intervention plays a minimal role in Elias’s and Winston’s
story. Their inclusion alongside the first two stories must be understood in light of Greg
Eghigian’s (2011: 203) timely reminder that contemporary psychiatry is “a way of knowing and
acting upon the world” that implicates myriad cultural resources. In an effort to encourage his
fellow historians of psychiatry to “deinstitutionalize” their research programs, Eghigian (2011:
203) urges his colleagues to ask, “where is psychiatry taking place”? Where is psychiatric
knowledge housed and put into practice? In each of the above stories, texts in which authoritative
voices are embedded serve as efficacious placeholders for authorities—people—who are rarely
present when their clients find themselves wrestling with the pragmatic and philosophical
challenges of balancing medical advice with other priorities. When I first listened to the above
stories, I paid little attention to the fact that Helen, Armaghan, and Elias had mentioned specific
news sources when establishing the background to the eventual plot complications. It was only
later, when I heard the stories retold in part or in whole—over coffee, during streetcar rides,
during subsequent group meetings—that I came to appreciate the consistency with which parents
brought up these news sources. Helen was always emphatic that it was the Toronto Star’s
coverage of childhood disorders that had inspire

d her to have her son evaluated and diagnosed.
When retelling her story to newcomers, Armaghan never omitted the incident in which Magda’s
psychiatrist retrieved a stack of photocopied TIME articles from the 1990s (“like this,” she
always stressed, illustrating the thickness with her thumb and forefinger). Magda herself used
scientific news releases and the authority of the printed page to destabilize her parents’ moral
authority. Thus, the fact that Elias’s (not even Winston’s) psychiatrist played virtually no role in
his story of desperation and revelation does not mean that psychiatry writ large played no role.
Elias’s persistent online sleuthing for a “miracle diagnosis” to explain his son’s sullenness drives Eghigian’s point home: psychiatry is “taking place” when our interpretations of others’ behaviours are mediated by the authoritative representations and iconographies about behavioural pathology in which we are all immersed. At the same time, it is important to note that these representations do not always resonate with their audiences. The fact that Elias was so put off by Moods magazine’s phrasing choices (“The enemy is...”) that he abandoned the psychiatrizing project altogether reflects his discomfort with the magazine’s adversarial stance toward “mental illness”—a stance that is common in our society (see chapter 4). Although Elias reads in Moods that guiding resistant “mental illness” sufferers to treatment is a moral imperative, he cannot bring himself to follow through, because he sees no clear way to separate “the brain dysfunction” from “the person,” and is unwilling to “conspire” against the person. He is, in the end, unable to reinterpret Winston’s silent glower as a result of mere ventriloquism, viewing it instead as an indication of hostility. While Winston revealed few details about his achieved recovery from his self-injury habit (aside from the methodology he deployed), the very fact that he was able to disburden himself of an unwanted addiction on his own destabilizes the notion that a refusal to seek help is predictive of poor outcome.

Magda’s story exemplifies a major pitfall of overemphasizing “compliance” as a determinant of recovery. There are basically two halves to her experience with psychiatric intervention. In the first, she is forcibly hospitalized, assigned a slew of diagnoses, and coerced into ingesting medications that wreak havoc on her mental state; she overtly resists the treatment plan, and her every familial interaction is riven with strife. In the second, she playacts obedience and defers to her parents’ and physician’s wishes, pretends to ingest the medications, modulates her behaviour to fit therapeutic expectations, and conceals her authentic desires; she covertly resists the treatment plan, and peace is restored within her family. Indeed, she is declared to have made a full recovery by her psychiatrist, in spite of the fact that she in fact felt less well and was under more stress during this period due to her need to clandestinely regurgitate food. Because Magda’s wishes and claims are not taken seriously (during her anorexic phase), she eventually sees no point in continuing to speak her mind, and decides to pursue her goals in secrecy (during her bulimic phase). Even though the “good insight” that she displayed during the second phase was essentially a false recantation of beliefs that she still held, the falsity of the recantation is not

---

104 A more trivial example of the gap between representation and lived reality is visible in the fact that Matt’s psychostimulant is named “Concerta” (one letter off from the very harmonious sounding concert and concerto), which contrasts sharply with the significant disharmony that the drug induced in Helen’s family dynamic and in Matt’s body.
visible to the clinical gaze: what matters is the performance. Magda’s story of sustaining exterior sanguinity despite interior pain echoes Judi Chamberlin’s recollections of similar imperatives faced by psychiatric inpatients:

I gritted my teeth and told the staff what they wanted to hear. I told them I was glad to be in the safe environment of the hospital. I said that I knew I was sick, and that I wanted to get better. In short, I lied… I learned to hide my feelings, especially negative ones. The very first day in the state hospital, I received a valuable piece of advice. Feeling frightened, abandoned, and alone, I started to cry in the day room. Another patient came and sat beside me, leaned over and whispered, ‘Don’t do that. They’ll think you’re depressed.’ So I learned to cry only at night, in my bed, under the covers, without making a sound. … I became a good patient outwardly, although inside I nurtured a secret rebellion that was no less real for being hidden (1998: 49; emphasis in original).

When the prevailing cultural wisdom is that “mentally ill” people need to be good patients and to comply with medical directives in order to recover, it can be extremely difficult for dissenting patients and skeptical caregivers to find ratification for their dissent and skepticism. As Gabriel (2004: 176) has noted, when lay and expert claims come into conflict, it is laypeople’s knowledge of their own lives that tends to be “relegated to the standing of ‘mere opinion,’” not experts’ knowledge. Consequently, patients who withhold information from their clinicians (e.g. Magda’s secret bulimia, Olivia’s and Cassidy’s unilateral discontinuation of their drugs), caregivers who withhold information from clinicians (e.g. Matt’s parents allowing him secret “holidays” from Concerta), and even non-patients who “fall through the cracks” by evading the medical purview altogether (e.g. Alyssa, during her self-destructive period; Winston, during his recovery from “cutting”) tread dangerous ground: they need to maintain the secrecy of their unruliness in order to forestall unwanted interference and moral judgement. In light of the regularity with which “mentally ill” people have their liberties suspended against their will, the secrecy is understandable (see Andre 2009, Rabinowitz 1994). But it is precisely because transgressive people know better than to advertise their transgressions that today’s psychiatric master narrative—medicalization and medication lead organically to recovery—is so infrequently contradicted in public. As Breggin and Cohen (1999) point out, when dissenting patients quietly remove themselves from the medical purview, the purveyors of medical knowledge end up never having to face their critics:

Precisely because many doctors express a negative or antagonistic attitude about drug withdrawal—especially withdrawal that the patient initiates, controls, and evaluates—they are not likely to accept or welcome reports of positive results. Our clinical experience indicates that when patients successfully stop taking psychiatric drugs on their own, they usually do not tell their former doctors. Patients are even less likely to tell their doctors if the relationship was superficial or centered around the prescription. Frequently, patients are too angry or afraid to communicate with the doctor, or feel insufficiently cared for. Thus the doctors simply do not learn that withdrawal can be accomplished effectively (Breggin and Cohen 1999: 115, emphasis in original).
It is worth noting that dissenting patients and caregivers are not the only ones who withhold information. Physicians do not always explain possible adverse reactions to drugs in a clear and detailed fashion; nor do they always explain that the long-term effects of newly marketed drugs are unknown; nor do they typically warn patients that because clinical trials test individual drugs, little is known about the \textit{in vivo} interactions of multiple drugs prescribed as part of a polypharmaceutical treatment plan (see Capponi 2003, Healy 2006, Lexchin 2005). Physicians cannot necessarily be blamed for these lapses given that many are in fact unaware of or insufficiently knowledgeable about these points; indeed, a recent study estimates that “psychiatrists obtain approximately 70 percent of their information regarding medications from brochures distributed by sales representatives of drug companies” (Applbaum 2006: 105; see also Paris 2008). Because drug manufacturers are responsible for testing their own drugs, they are free to withhold unfavourable or unflattering results from public scrutiny by simply not publishing them, meaning that even doctors who follow scholarly journals to learn more about particular drugs’ efficacy cannot access all the relevant data (Goldacre 2012). While doctors are not responsible for regulatory loopholes or corporate malfeasance, it must be remembered that a patient’s “informed consent”\textsuperscript{105} is not truly possible in the absence of these, and other, disclosures.

4. \textbf{On Other Forms of Insight}

4.1 \textit{“You Have to be Brought to the Depths of Hell.”}

MacDaniel was a quiet man, and it was sometimes hard for me to envision him in the situations he described on the rare occasions he spoke about his past: running along a set of railroad tracks yelling in the middle of the night, repeatedly punching a wall until his knuckles bled, smashing all of the dishware he owned because he found their patterns too distracting. Although he no

\textsuperscript{105} “Informed consent” has become a rallying cry of psychiatric survivor activism due to Western psychiatry’s long history of endorsing procedures whose harms later turned out to be predictable and indisputable (e.g. lobotomies, insulin comas). As survivor activist Mary Maddock (2006: 126) argues, “I’m not saying… that these drugs cannot be of benefit to people. What we do say is that all the facts relating to them must be made available and people can then have a choice.” Because psychiatric patients face the special challenge of overcoming skepticisms about their very ability to weigh options and make choices, they are faced with a triple dilemma. Due to the invisibility of psychiatric survivors’ firsthand testimonies in the mainstream media, patients’ reluctance to “consent” to medication may strike their doctors and families as aberrant, unreasonable, even dogmatic—rather than consistent with the experiences of hundreds of other/former patients. Moreover, because full disclosure of a drug’s health risks may discourage patients from taking it regularly, clinicians may downplay their knowledge of such risks. However, it should be noted that an exclusive focus on establishing conditions for “informed consent” may foreclose other avenues of anti-psychiatric critique (e.g. if all data about drugs’ health risks were made freely available, this would surely confer greater legitimacy upon the claim that patients who reject current or future medications \textit{not known for incurring intolerable side effects} must do so only due to their lack of “insight”).
longer considered himself an Unhinged member and had not attended a meeting in over two years at the time I gained entrée to the group, he was one of its founders and he considered Ryan one of his best friends. Hence, he stayed in close contact with the regulars, and it was in this capacity that I met him. While playing cards and chatting in Ryan and Olivia’s living room one evening, he casually shared some of the lessons he had learned during his stint as a psychiatric inpatient, with the explicit aim of equipping me with some “tips” that would serve me well if I ever found myself involuntarily committed. To win his freedom, he said, he had learned to subtly adjust his words and behaviours to match those of the staff. “Be scared of whatever they’re scared of,” he counselled. “The guy yelling down the hall. The economy.” He explained to me how, when given pills to take, he would pretend to swallow them by clapping his palm to his face, throwing his head back in one smooth motion, and then drinking the little cup of fruit juice the nurses provided. In actuality, he would insert the pills into his nostrils; he would then melt them with hot water in a bathroom sink when he was alone, or simply wrap them in toilet paper and flush them. “When they ask you, ‘Why do you want to get out,’ don’t say, ‘What kind of question is that?’” he advised. “Just play the game. Say you want to get better and do something with your life.” MacDaniel was particularly emphatic about the importance of keeping one’s eyes slightly down when talking to staff, in order to put them at ease. “And never sing,” he warned, as doing so would incur the unnecessary risk of annoying or alarming the staff. “Make up whatever you need to. Get a good notation,” he said. “You want it so every night you get a notation saying something like, ‘cooperative,’ or ‘polite.’” Above all, he urged me never to accept the truth of any diagnosis that I might be given, even if I had to pretend that I did. “Protect who you are, in here,” he advised, patting the left side of his chest. “Keep it safe.”

MacDaniel was never interested in revealing many details about his life. However, he did tell me that he had been diagnosed with schizotypal personality disorder as a teenager, that he had not had any contact with his natal family in over a decade, and that he was categorically opposed to psychiatric labels and forcible treatments. Now in his thirties, he made it very clear to me that he identified as neither a “schizotypical,” nor an “ex-patient,” nor a “consumer,” nor a “psych survivor,” nor a “mad” person, nor an “anti-psychiatry” activist. “I’m just a person,” he often said. His first and only hospitalization had taken place after he had run away from home for

---

106 This diagnosis is classified as a personality disorder in the DSM-IV, but as a variant of schizophrenia (“schizotypal disorder”) in the World Health Organization’s ICD-10; this discrepancy has been a source of controversy in the psychiatric community, as schizophrenia is seen as having a far worse prognosis than any personality disorder. By noting this, my aim is not to reinforce the legitimacy of either label, but to draw attention to the high level of conceptual uncertainty that surrounds current understandings of the “schizophrenia spectrum” (Mamah and Barch 2011; see also Cockburn and Cockburn 2011, Jenkins and Barrett 2004, Urdaniz et al. 2005).
undisclosed reasons and spent hours following a set of railroad tracks while talking to himself before being picked up by police. Upon his admission to a psychiatric ward, he was given an injection that incapacitated him; upon awakening, he was given a second injection that rendered him physically incapable of producing verbal speech (“it freezes up your vocal cords, so you can’t do much more than drool”). He suspected that this injection was an antipsychotic called Haldol, which other psychiatric survivors have charged with similarly impairing their verbal capacities (e.g. in Burstow and Weitz 1988, Shimrat 1997: 15). After several weeks in the ward, MacDaniel’s treatment regimen was altered to a series of oral medications, which did not impair his physical capacities quite so dramatically, but which he nonetheless found unendurable.

It was this odd sort of candy-stripe, sort of mealy, kind of foggy sort of thing, which if you’re anything like me, it’s a gross feeling. You become very concerned about getting through it and if it’s working, and you do worry about losing yourself to this, and it is what it is, losing yourself to this violation. What they do, the meds do, is rob you of your anger. Which you need, any little pinprick of energy you have, you need to fight the drugs’ effects.

During another conversation, he compared the drugs to what he called “Purple K,” the nickname for potassium bicarbonate when it is employed as an extinguishing agent on oil and gas fires. “It suffocates the fire inside,” he said. I became confused during this exchange, as I had never heard of “Purple K” before, and I made a remark about “Special K,” the Kellogg breakfast cereal. This prompted MacDaniel to relate another anecdote about his hospital stay, in which a “cheery, singsong-y” occupational therapist told him that he had to “be more realistic” when he told her of his dream of traveling the world.

Let’s stick to making porridge, is what she said, and they do speak in the first-person plural with patients. Let’s learn how to make porridge. Let’s not try too hard. Let’s aim low. [Eugenia: She said that?] No, what she said was, she laughed, and, word for word, what she said was, ‘Let’s stick to making porridge.’ ((shrugs)) What’s your take?

MacDaniel contended that it was only after he began faking compliance and secretly discarding his medications that the “mealy,” “foggy,” “candy-stripe” feeling lifted, resuscitating the anger he needed to successfully win his release. When meeting with clinicians, he learned to dissimulate about his thoughts in order to earn their trust (“three things you never want to even acknowledge—never, okay?—is daydreams, imaginary worlds, and politics”). He learned to respond politely to all inquiries, even as he nursed secret fantasies of rebellion. When a psychiatrist told him that if he stayed on his medications, “you might even be able to live in the community again,” he resisted the urge to repudiate the doctor’s assumptions by revealing that he had been secretly off his medications for weeks; instead, he simply replied, “I’m looking forward to it.” Upon his eventual release into his parents’ care, he made the decision to feign
medication compliance until his eighteenth birthday, which was less than a year away. He told me that when his parents were out of town one weekend after he had turned eighteen, he moved all of his belongings into “a shitty little closet-sized room,” which he had arranged to rent on his meagre income as a restaurant server/dishwasher. When apprising them that he had moved out, he assured them that he had the income to cover the costs of his antipsychotic prescriptions (“I made this beautiful budget on a spreadsheet, completely gamed [manipulated or fudged]”), and he promised to take his medication regularly. In actuality, he did not have the funds to cover his prescription fees, but this was not an obstacle because his plan was to not fill his prescriptions, to not return to his psychiatrist, and to simply disappear from the psychiatric system altogether. As he put it, “I don’t even go to doctors anymore.”

MacDaniel seemed to see this as the organic conclusion to his story, and he was never interested in chronicling his life subsequent to that point. I did not wish to discomfit him by prying. However, I did ask him if he had seen his family since he moved out, and if he harboured any regrets for the way in which he had left.

Yes and no. I’m saying that—obviously it’s not a perfect outcome. I did go to a couple of Christmas dinners. My father, apparently, saw fit to tell everyone, because they knew before I had arrived, he told everyone I had schizophrenia, and be careful, which ((pauses, notices the expression on my face)) yeah, no, anything schizo—anything sounds the same to anyone. And here—well, first of all, you notice a bit of edginess, it’s this thing where you’re kind of circling each other. You have to put up fronts, like, ‘I do have a job,’ ‘I’m taking a class,’ where nothing you say is ever just a thing to say, anything can be used against you. Let’s say over Afghanistan, you cannot talk about the CIA, cause you do have this fear ((mimics a family member whispering)) ‘Oh, what if it’s paranoid delusions’… You do get tired of it, and, I want to be honest with you, not everyone’s raised in a home they want to see again.

MacDaniel often couched his observations in the form of unsolicited advice, which his friends did not always appreciate. “You have to pledge to yourself, never to be helpless again,” he once said during a conversation about how to forestall unwanted psychiatric intervention. When Ryan objected (“Fucking huge amounts of people are helpless whether they want it or not!”), MacDaniel shook his head. “I’m not talking about them. I’m talking about you, and you, and you,” he said, indicating Ryan, Olivia, and me.

You have to pledge to yourself, ‘I will not have a shitty life. I am not mentally ill.’ No one’s coming to rescue you, there’s not a lifeline to a better place. You, you, have to decide to stop hurting yourself, you have to realize, no one cares you put your fist in a wall, and who cares if they care. Put your fist in the wall, sink into bloody rock bottom, but a time comes when you have to redirect the anger in an outwards way, away from yourself.

Like Alyssa’s private admonition about the tyranny of the category (“there are some things you can do for yourself, when you break out of this helpless mindset”), MacDaniel’s caution about the perils of relying on others acquires its sensible feel from an underlying conflation of survival
and merit, which transforms the goal of living a decent life into a “pledge”—a commitment to calculate, negotiate, plan, and labour to the best of one’s ability until one’s needs are fulfilled, a point whose ramifications we will return to shortly.

Unlike Ryan and Olivia, MacDaniel never attended political demonstrations. Indeed, he emphatically wanted nothing to do with the leftwing political scene—whether within the psychiatric survivor/mad/anti-psychiatry movements or within related social movements—although he stated that his political views were situated firmly on the left (see chapter 7). “Living well is the best revenge,” he once insisted during a discussion about the diverse forms that anti-psychiatric dissent can assume. The fact that he had successfully disproved his clinicians’ pessimistic prognoses was, for him, an adequate signifier of personal victory, and he felt no need to convey his dissent in a more militant register. However, he at times hinted that his declination to identify as a “psychiatric survivor” was motivated by a desire to avoid eliciting stigma or unwarranted fears. “Sometimes, you do want to brag about rescuing yourself,” he remarked to me while walking along Queen Street East one sunny afternoon. “But then people go, ‘from what?’ Psychophobia is a hard nut to crack.” During that walk, MacDaniel described to me what he called his “theory of recovery.”

You have to be brought to the depths of hell, the worst despair. You have to be in a state of such unqualified anguish that it’s you who wants your life to change, not anyone else, not your parents, not some guy with a diploma.

He speculated, correctly, that many psychiatric survivors had likely been telling me that what they had needed most was “someone to talk to,” and he insisted that anyone who made this claim was being naïve (“you have to learn to go it alone”). He added, “And you’re probably getting a lot of young people saying, ‘money can’t buy happiness.’ They’re wrong. Maybe they don’t know it yet.” He then listed off the three ingredients that he saw as necessary, albeit not always sufficient, for extricating oneself from this state of ultimate suffering: “a job, a place to live, education.” When I began to comment on the costs of postsecondary education, he interrupted me in mid-sentence. “I don’t mean ten years of grad school. I mean learning why things are the way they are.” As we made our way along the sidewalk, glancing into storefront windows every now and then, he elaborated on what he meant. “Let’s say you go to the doctor, and you have a cold,” he began. He developed a parable about a hypothetical patient who regularly develops respiratory tract infections, who sees her doctor month after month, and who is sent away from each appointment with prescriptions for various antibiotics, analgesics, and decongestants. From her doctor’s office, the hypothetical patient heads straight to the pharmacy to have her
prescriptions filled, hopeful that one of her new medications will solve her problems. She then returns to her home, “a cardboard box on a street of cardboard boxes.” The moral of the story, MacDaniel explained, is that the hypothetical patient has been taught to believe that she lives “in the best world,” and therefore sees living in a cardboard box as entirely normal and unremarkable. As a result, even when her doctor inquires about potential environmental determinants of her illness, it never occurs to her to bring up the fact that she is living in a structure that is permeable to wind and rain.

“What you need is to learn how things got this way, to learn the history, so you won’t put up with it when you’re told, ‘this is just how things are, live with it,’” MacDaniel concluded. He gestured at a pharmacy across the street, whose storefront sign displayed a large Rx logo. “What you don’t need is to be turned into a zombie drug addict,” he then added, unaware or unconcerned by the heavy burden he had just placed on those “addicts.”

* * *

Educational theorists have long noted that an unintended outcome of requiring students to avoid penalties and earn rewards in order to advance through a curriculum is that students can learn to excel by focusing on proximate goals (e.g. getting good grades) at the expense of ultimate ones (e.g. cultivating their creative energies, sharing ideas, realizing their intellectual potential, actually retaining what they learn; see Dewey 1997, Hayes and Wynyard 2002). While the analogy is imperfect, I want to suggest that the current canons of psychiatric “recovery” can foster similar confirmation biases by creating conditions that encourage patients to pursue proximate goals (e.g. earning good evaluations in order to get discharged from a facility, refraining from saying or doing anything that may jeopardize domestic peace) that end up overriding ultimate ones (cultivating lives that they find fulfilling). MacDaniel’s litany of recommendations for achieving a swift release from psychiatric custody are a case in point.

Whether or not his own inpatient experience was indeed marked by the skilful behavioural and rhetorical refinements with which he credited his eventual discharge, he was emphatic that he neither agreed with nor cooperated with his clinicians at the time; he simply pretended to agree and comply. As Summerson Carr found while studying an outpatient drug treatment program, because social workers are empowered to both facilitate and deny their clients’ access to basic goods and services, those clients “understandably try to anticipate and control how their words will be taken up by their counsellors and case managers” (2011: 3)—often by producing well-rehearsed confessions of disease, denial, recognition, and recovery that are pleasing to the
professional ear but wholly fictitious. A similar principle obtains in psychiatric systems. Because of the extreme power imbalance in the psychiatrist/inpatient relationship, in which one party’s philosophical convictions determine the other party’s living conditions, it is not surprising that one of the commonest themes in psychiatric survivors’ narratives is the enjoinder to *play the game*: to do whatever it takes to gratify one’s custodians; to say yes, no matter how vehemently one wishes to say no.

Like Cassidy, MacDaniel’s story of psychiatrization both culminates in a decision to never again return to the psychiatric purview and includes a denouement in which a family member serves as an extension of psychiatry’s moral gaze, thereby forcing the surveilled person into silence and secrecy. While MacDaniel’s hospitalization in fact began with an injection that forced him into physical silence (“it freezes up your vocal cords”), he did not find his need to maintain a figurative silence at his family’s Christmas dinners any less frustrating. It is interesting to contrast his father’s disclosure of his diagnosis to his relatives with his subsequent inability to talk about the CIA’s activities in Afghanistan. Whether or not this was his intent, MacDaniel has highlighted a brutal irony of psychiatric reasoning: although the “mentally ill” are frequently stereotyped as sources of potential violence, it is the “mentally healthy” who most often foment actual violence on a large scale. Given that psychiatric inpatients are frequently violently subdued in hospital wards with chemical and physical restraints, MacDaniel’s fear of potential psychiatrization at the hands of his relatives or others who are “psychophobic” brings to mind Joshua Barker’s insight about discursive systems that equate alterity with danger. While such discourses make it possible to “name certain forms of ‘otherness’” as threats to civil society, “for those who are categorized as one of the threatening others and for those who question whether or not they might be, this ordering of the world can itself lead to a great deal of fear” (Barker 2009: 267).

MacDaniel’s departure from the psychiatric purview and his achievement of a peaceable life (“the best revenge”) have been made possible by a combination of traits and states that mainstream psychiatry construes as dangerous, undesirable, and irresponsible: a rejection of illness labels (“I’m just a person”), non-compliance with treatment, fastidious efforts to fall through the cracks (avoiding doctors altogether, declining to publicly “brag” about having rescued himself from psychiatry), and feelings of anger and resentment about the chemical suffocation of his internal “fire.” Indeed, the virtue he consistently sees in “anger”—as something that was medicinally “robbed” from him and something to “redirect… in an outwards way”—clashes with a primary goal of modern psychiatry, namely to help patients become better
adjusted to environmental stressors and moderate their emotional reactions (American Psychiatric Association 2000: 679-683). MacDaniel’s parable about the cardboard-box-dweller with the recurring chest infection in fact stands in stark contrast with the psychiatric valorization of adjustment. An underlying message of his story seems to be: suffering people should not adjust to the conditions of their suffering; they should instead learn about the injustice of their living conditions, “so you won’t put up with it when you’re told, ‘this is just how things are, live with it.’” His parable thus contains the seeds of an anthropological analysis, in which

with medicalization, attention is deflected away from the social arrangements and political forces that contribute to the incidence of distress and disease… Subjectivity and symptom reporting are subsumed into medical pathologies and standard deviations from medical norms, and the focus of attention is on bodies of individuals, who are essentially made responsible for their own condition (Lock 2001: 481).

Bradley Lewis (2006a: 134) has pointed out that if an anguished person can be restored to tranquility with the right ingestible or injectable, there “is no need to reduce social harassment, discrimination, gross inequities in opportunity, or corporate-media-induced status anxiety” or wrestle with other complex political questions. The personal, rather than being political, is now neural. Thus, by insisting that anger and anguish have value in and of themselves, MacDaniel is likewise suggesting that the “solution” of targeted neurochemical treatment is no solution at all: becoming desensitized to oppression is not the same as living a life free from oppression.

MacDaniel’s description of psychiatric consumers as “zombie drug addicts” took me by surprise, as it struck me as excessively hostile to a class of people who are, after all, precisely those whom he identifies as the victims of the status quo. However, this designation puts an ironic twist on theoretical paradigms in contemporary mental healthcare, in which substance addiction is conceptualized as a “mental illness” and represented by a range of DSM codifications that cover everything from adverse reactions to an initial drug encounter to end-stage withdrawal syndromes (American Psychiatric Association 2000: 191-295). Like Olivia and Cassidy, MacDaniel is implying that psychopharmacological treatment induces, and may even be, a chronic illness. This view is fortified by his invitation to other psychiatrized people to “pledge to yourself, ‘I will not have a shitty life. I am not mentally ill’”—in a sense, a call to have “poor insight,” so as to reject the low expectations of society and defy the fatalism and resignation connected with acceptance of mental illness. His subsequent insistence that a person must be “brought to the depths of hell, the worst despair” to be authentically motivated to change thus has two implications in a psychiatrized society that treats “the worst despair” as a form of poor mental health. The first is that the premature suppression of despair and other negative emotions (i.e. the automatic recourse to drugs) can sometimes obstruct a person’s existential
journey to wellness. The second is that feelings of crushing sadness and madness can be valuable to the person experiencing them, and that people can have rational reasons for objecting to medically induced equanimity whether or not the medications are linked with ghastly somatic side effects. Despite MacDaniel’s strenuous aversion to political activism and the labels deployed in activist circles, he seemed to be advancing an argument with a long history on the radical left: outrage, desperation and discontentment are necessary ingredients for change.

At the same time, a strong thread of neoliberal moralizing can be detected in MacDaniel’s tripartite theory of recovery (“a job, a place to live, education”). “You have to learn to go it alone,” he had stated in anticipation of other psychiatric survivors’ identification of social support networks as key determinants of wellness, and in alignment with political ideologies that conflate freedom with market shrewdness. In a competitive economy where each of us “is always faced with one’s self as a project that must be consciously steered through various possible alliances and obstacles… using a means-ends calculus,” individuals have come to be seen as “maximally responsible for their failures” despite the uneven playing field (Gershon 2011: 539, 540). Under such forms of commonsense, acts of survival and acts of virtue become conceptually blurred: a psychiatric survivor who learns to “go it alone” may meet with MacDaniel’s approval, but what if her best efforts eventually prove inadequate? As Ilana Gershon (2011: 542) reminds us, “experts are the neoliberal preferred technology of regulation when selves go awry.” We are thus returned to the logic of mandatory psychiatric intervention: the moment at which an individual can no longer counterbalance risk with responsibility, no matter how hard he works, thinks, plans, or prepares, is the moment at which professional help is required. Failure to present oneself for such help signals either immorality (e.g. burdening others who must take up the slack) or irrationality (e.g. being unable to see that one’s deficiencies are burdening others) and represents further evidence that something is wrong. It is in this light that MacDaniel’s disavowals of political activism and celebrations of willpower acquire quite political consequences: in the absence of supportive communities like social movement groups, the rich relational networks cultivated within them, and the transformative resources they offer, the sole recourse available to those who cannot escape trauma, dysphoria, or despair is the psychiatric system. To recognize that we are not always the authors of our own destinies is not to concede that mental illnesses are. It is, rather, to acknowledge that “people require more than the limited connections offered by neoliberal conception of relationships” (Gershon 2011: 545).

Although MacDaniel was uninterested in disclosing details about the span of time following his departure from his parents’ home, it is clear that he had the communicative and
material resources necessary to secure a job and a place to live, and that, irrespective of the intervening events, he was now living the type of life that he could comfortably describe with the aphorism, “Living well is the best revenge.” On the one hand, he is correct that housing and employment are strongly correlated with better health outcomes and lower rates of mortality and morbidity in relation to a variety of conditions; indeed, it has been demonstrated time and time again that affordable housing is instrumental to lowering confinement rates in psychiatric institutions (Baer et al. 2003; see also chapter 7). On the other hand, a person’s ability to successfully put a roof over his head is strongly contingent on variables over which he himself has little to no control: the language he speaks, the colour of his skin, the extent to which his society values or disvalues the knowledges he has accumulated in the course of living his life. It would be no indictment of MacDaniel’s level of commitment if, under different circumstances, he had been unable to achieve the best revenge by living well: his inability to clinch a job and a home, or to enhance his understanding of historical events so as to fuel his inner anger, would reflect neither illness nor weakness.

When I later asked MacDaniel how he had come “to learn how things got this way,” he rattled off a litany of authors whose writings he had read, and whose names could easily populate any social science syllabus: Louis Althusser, Donna Haraway, Michel Foucault, Alice Walker, Paulo Freire, Antonio Gramsci, and many others. Like Cassidy, he had spent a lot of time and energy reading and researching in the years since his brush with psychiatry. Although he demurred in his characteristically evasive manner when I asked him to specify the contributions that these authors had made toward his anti-psychiatric outlook (“Why would you think there’s anything specific? All it is, is getting a bigger picture on how power works”), it was clear that he took great pride in being the most well-read person in any given conversation. Nonetheless, the historical and theoretical knowledge that he had acquired from culturally prestigious texts was not the only form of knowledge from which he had benefited during his efforts to liberate himself from psychiatry. Toward the end of my fieldwork year, he acknowledged that he had omitted a salient fact in his story about his hospital stay. “Without the other inmates on my floor, I don’t think I could’ve known what was happening in me, to me,” he stated, in reference to exchanges he had had with his fellow inpatients about their medications. “They were the only ones who were up-front with me about the side effects.”
4.2 When Compliance is Incompatible with Comprehension

“When Compliance is Incompatible with Comprehension

“A basic premise of science and research is also a value of Madness: to share your findings with others.” (Sylvia Caras, coordinator of an online discussion group called Madness; quoted in Shimrat 1997: 164)

When Patricia Deegan was a teenager, she was diagnosed with schizophrenia and given “a prognosis of doom” by her psychiatrist, who told her that she would have to take antipsychotic medications for the rest of her life (2007: 62). After being discharged from the hospital, she threw away her medications and was returned to the hospital after reverting to the disoriented state that had brought her into the psychiatric system in the first place. Her psychiatrist saw this act as an indication of “non-compliance” that “not only reflected a lack of insight, but was also a symptom of my illness” (Deegan 2007: 63). Deegan, in contrast, saw the act as an expression of dissent, motivated by her vigorous objection to being assigned “a profound message of hopelessness… a life of chronic illness from which it seemed there was no escape” and being urged “to take powerful drugs that often have noxious and dangerous side effects, for the rest of my life” (2007: 63). Eventually,

I did learn to become compliant and took psychiatric medications as prescribed. Mine became a passive stance of taking medications faithfully, and then sitting all day on a couch, smoking cigarettes, without goals or life plans. … my psychiatrist said I was getting better, but I experienced being disabled by the medication. He said I was more in control, but I experienced the medication controlling me. He said my symptoms were gone, but my experience was that my symptoms were no longer bothersome to others but some continued to torment me. He said I had returned to baseline, but I experienced, ‘I am not myself anymore.’ He said I was lucky to be living outside of the hospital, but I felt I was not really living at all. My psychiatrist was pleased with my progress. He said I was doing well for a schizophrenic. But my experience was of living in chemical restraints that created walls as thick and impenetrable as any institution, leaving me isolated from my world and alienated from myself. I lost years of my life in this netherworld, and although I was treatment compliant and was maintained in the community, I was not recovering (Deegan 2007: 63; emphases mine).

Deegan credits her entry into the postsecondary education system with her eventual recovery. She became interested in taking a college course and discovered that in order to succeed as a student, she would have to mobilize cognitive skills that her medications had made unavailable. By learning to mask her auditory hallucinations with headphones, she was able to dramatically reduce her antipsychotic dosage and thereby regain some of her mental alertness. As Deegan notes, eradicating her symptoms was not the pre-eminent priority in her life; her “primary goal at that time was going to school” (2007: 64). She discovered that she was better able to cope with the demands of her academic program when her symptoms were present than when they were chemically suppressed: as she put it, “Striving for complete symptom abatement meant I had to take so much medication that I became somnolent and could not learn” (2007: 64). Deegan
eventually earned a doctorate in clinical psychology and became a prominent activist in the American psychiatric survivor community. What is noteworthy about Deegan’s experience is that she did not categorically reject pharmacological treatments. What she rejected at first was her psychiatrist’s “profound message of hopelessness,” and what she rejected later on was the total suppression of her auditory hallucinations, which was inevitably conjoined with the suppression of her intellectual capacities. For Deegan, learning—the ability to learn and the act of learning—was a stronger determinant of wellness than biological normalization at all costs.

Deegan’s story came to mind when Richter (an Unhinged regular) one day presented me with a copy of a broadsheet newspaper called Depression Expression. The single-issue newspaper was dated 2006, and its editorial masthead identified its publisher as the Toronto-based environmentalist mental health group Greenspiration. “Look at this stuff,” Richter said. “Look.” He leafed through the issue, pointing out the various first-person testimonies that filled its pages (see Figure 6.4 in Appendix II). The main item to which he wished to draw my attention was a sidebar that chronicled the experience of a woman from Vancouver, part of which read:

Thinking—that is the key. When your brain is on psychoactive drugs, you really cannot think clearly. Your brain is disabled. You cannot see or analyze what is going on, you cannot think to get out and try alternatives. I certainly could not. I was in a daze. ... It wasn’t until an incident that traumatized me deeply woke me up, that I started to question, even in the fogginess of medications, what was going on. I read everything I could get my hands on. I took myself off meds. I fired the ‘professionals.’ My mind began to clear up, my memory started to improve. I could think, I could concentrate, I could feel, I could stay awake, I could function again. The withdrawal was hell, but well worth it. I'm myself again, which I haven't felt in close to a decade (“middle-aged woman” from Vancouver, BC, quoted in Depression Expression 2006: 8; emphases mine).

I asked Richter if I could make a copy of this page, and he encouraged me to keep the whole issue, as he already had multiple copies. While reading the publication later that evening, I noticed an article by Josephine Grey, the director of a local anti-poverty group called Low Income Families Together, who also indicted the tendency of psychopharmaceuticals to impair patients’ cognitive capacities, but whose conclusions were somewhat broader in scope:

People in poverty are often afraid to refuse the pills, even if they have heard about safety concerns, as they feel that they must cooperate to receive needed treatments and to encourage doctors to verify their eligibility for various forms of public assistance... it seems to me that the most sinister effect of all is that most poor and disenfranchised people, once hooked by a doctor on pharmaceutical brain chemicals, lose the ability to engage in organizing themselves to respond to systemic problems. When we lose the capacity to defend each other and ourselves, we become passive victims of bad employers, landlords, welfare workers and other systemic forces that run and can ruin the lives of the poor (Grey 2006: 18; emphasis mine).

In each of the scenarios outlined above, psychopharmaceutical interventions are depicted as forces that make it difficult or impossible for patients to think. Patricia Deegan’s antipsychotics
suppressed her mental acuity and physical energy (albeit not her auditory hallucinations),
resulting in an intolerably somnolent state that her psychiatrist identified as a return “to
baseline.” The woman from Vancouver ascribed similarly oppressive effects to her drug, which
made her unable to “see or analyze what is going on.” Josephine Grey was even more explicit:
because psychopharmaceuticals can impair people’s capacities to see or analyze what is going
on, they are in a sense impairing people’s abilities to become collectively organized and
politicized on a large scale. Many of the stories that I have discussed in this chapter—Cassidy’s
and MacDaniel’s in particular—also implicate psychiatric medications as agents that sabotage
their users’ critical thinking skills. For Cassidy, fear was an integral component of her reasoning
process, and the loss of fear she experienced on Prozac made it difficult for her to make
appropriate judgements about her financial situation. Cassidy’s later discovery of the anti-
psychiatry movement and her communications with On Our Own made it possible for her to
identify as merely one of “a whole bunch of people,” thus assuring her that her objections to
Prozac were indeed rational. For MacDaniel, a prerequisite to his becoming educated was his
capacity for anger and outrage, which had initially been extinguished by the antipsychotics he
equated with the fire suppression agent “Purple K.” In his eyes, it is non-compliance on a broad
scale that enables freedom of thought—a refusal to agree with the naturalness and correctness of
“how things are”—while compliance simply turns people into “zombie drug addicts.”

What I want to highlight in all of these cases is not simply the fact that each narrator
operationalizes a distinction between “compliance” and “thinking,” in which the two states are
treated as mutually exclusive, but the fact that access to information is the prime mover of
recovery (however defined) in each story. Deegan now identifies as fully recovered from her
illness, not because she no longer experiences auditory hallucinations, but because she earned a
postgraduate education and has become an activist and educator. The woman from Vancouver
crafted a concise narrative about recovery, in which she first “read everything I could get my
hands on,” then “took myself off meds,” and finally “fired the ‘professionals’.” It is only after
this sequence of events that she states that her “mind began to clear up… I could function
again… I’m myself again.” As we have seen, Cassidy’s story unfolded in a more cyclical
manner; she became depressed and anxious, took Prozac, rejected Prozac, then began to read.
When she became depressed and anxious again, she deployed her new knowledge and was
rewarded with immediately positive results, confirming for her the rehabilitative powers of
orthomolecular theory. MacDaniel also credited extensive reading (along with a job and a home)
with his current ability to exact revenge on psychiatry by “living well.” However, the fact that
his fellow inpatients furnished him with crucial insights into the adverse effects of his drugs at his most vulnerable point—without which he may have never been inspired to secretly take himself off of his drugs—bears out a vital aspect of Josephine Grey’s argument: when vulnerable people cannot organize with each other for whatever reason, they lose the capacity to defend each other and are more likely to be victimized. Acceptance members’ regular affirmations of parental solidarity bear out a corollary of Grey’s insight: it is precisely because they recognized that “what we see, nobody else does” (Armaghan) that they were consistently able and willing to defend/support each other whenever one of them admitted to having violated the advice of doctors and the mainstream media. Cassidy and MacDaniel sought their vindication in libraries, but found it also in the words of fellow survivors; the Acceptance parents were each other’s libraries.

The high premium that is placed on information-sharing in anti-psychiatry networks is of course also illustrated by the fact that Richter was the one who procured my copy of Depression Expression. In the same vein, without Elias and Armaghan, I would not have become sensitized to the extent to which publications like Moods magazine and TIME magazine shape, or are used to shape, family members’ attitudes toward the “mentally ill.” Indeed, as mentioned in chapter 4, the high level of distrust that many of my informants had for the mainstream news media and other founts of psychiatric reasoning (e.g. Bell Canada’s Mental Illness Awareness Week; Hollywood films involving “mentally ill” villains) meant that they constantly felt obligated to share useful tidbits of information with each other in order to compensate for the unreliability or unacceptability of mainstream news sources. The prolific references to independent news programs, feminist blogs, antiwar websites, and online essays on food insecurity, homophobia, immigration, free trade, and the labour movement that laced my informants’ electronic exchanges and casual conversations seemed, at first, tangential to my interest in their experiences of psychiatrization and survival. It eventually dawned on me, however, that alternative sources of information were instrumental to shaping their narratives of survival.

Anthropologists have long noted that alternative media sources can provide audiences with new vocabularies with which to pick apart conventional discourse systems: for example, by

---

107 Richter frequently went out of his way to collect interesting documents and artifacts for me, for which I am grateful. Toward the end of my fieldwork year, he gave me an item that was particularly direct about the rehabilitative virtues of non-compliance: a button badge designed to resemble a medical prescription, which stated, “RX, NON-COMPLIANCE... REPEAT: UNLIMITED.” The badge was created by Toronto’s Mad Students Society, a peer support organization for postsecondary students who are also psychiatric survivors/consumers.
calling attention to subtle ideological contradictions, or by revealing unpleasant truths about the consumerist lifeways toward which we are urged to aspire (Bird 2010; see also Coleman 2010, Spitulnik 1993, Wilson and Peterson 2002). In the next chapter, I will elaborate on the question of what happens when contrasting conceptions of “anti-psychiatry” come into conflict due in part to the competing views on social justice that permeate the leftwing political landscape, in which alternative media sources play a major role (Atkinson 2010; Bailey et al. 2008; Pajnik and Downing 2008). For now, I want only to make a final point about the link between non-compliance and “recovery,” a term whose definition I think can be demedicalized in light of the foregoing discussion:

To psychiatric survivors, recovery is the process of living a life that one wishes to live, the features of which are determined by the channels of information to which he or she happens to have access: reading books, talking to other people, listening carefully to his or her own body. On the basis of such experiences, my informants have learned that escaping psychiatry—being non-compliant and evading unwanted illness labels—is not only possible en route to a better life, but urgently necessary, in stark violation of three central pillars of the mainstream rehabilitation paradigm: that “mental illnesses” are incurable and manageable only with the aid of lifelong pharmacotherapy; that pharmacotherapy saves and does not sabotage lives; and that refusing to accept an illness label is a reliable predictor of poor outcome. Not everyone who falls into the psychiatric purview comes to reject all or any of these premises, of course. However, it is unsurprising that those who do will adopt an antagonistic stance toward practices and discourses they see as having divested them of cherished attributes and valued possibilities: “a normal life” (Olivia), fear and the love of journaling (Cassidy), sleep (Matt, as conveyed by Helen), mental and physical health (Magda), family harmony (Helen, Armaghan, Elias), anger (MacDaniel), a sense of personal uniqueness or authenticity (Ryan and others; see chapter 5), and the freedom to speak freely about their experiences without fear of stigma, suspicion, moral censure, or potential confinement (Cassidy, MacDaniel, Alyssa, Magda, arguably also Winston). Whether or not these individuals identify as “anti-psychiatry” activists, and not all did, it is understandable that they have come to identify psychiatry as a source of torment and invalidation, and a major cause of distrust within significant relationships (Cassidy and her sister, MacDaniel and his family, the Acceptance parents). Pierre Bourdieu (1977: 94) once noted that the “implicit pedagogy” of lived experience cannot always be dislodged by the “explicit pedagogy” of formalized educational curricula; this observation would seem to be borne out by the fact that the mainstream media’s widespread efforts to urge the detection and eradication of “mental illnesses” through swift
biopsychiatric intervention (see chapter 4) have not dissuaded any of my informants from holding anti-psychiatric views.

As I have alluded to throughout this chapter, people who are able to make a clean break from psychiatry and to (re-)constitute what for them suffices as healthy and satisfying lives are in a sense both casualties and beneficiaries of the prevailing social order. People tend to become psychiatrized in the first place because of structural or symbolic violence and unendurable social norms (chapter 5), as well as the fact that our society provides few options other than institutional biopsychiatry for those who are, or whose family members are, in a state of urgent crisis. The fact that some of my informants were able to mobilize their skills and energies to effect a permanent escape from psychiatry, or to evade it altogether, does not mean that they are stronger or smarter than those who did not, or could not, manage this. What it means is that, by dint of circumstance, they had access to material and conceptual tools that ultimately enabled them to achieve dignity on their own terms: information, nutrition, housing, friends, income, and motivating emotions like anger, fear, outrage, and pain. In sharp contrast with a conception of mental health that stresses lifelong compliance with pharmacotherapy, my informants’ refusal to be patients for life (or to maintain a serene *patience* for life) reflects not a lack of insight, but an irrepressible awareness that there are many forms of insight, and that it is those who transgress rather than those who comply with arbitrary benchmarks of virtue who learn to question their outcomes. As Alyssa noted, it is hard to “deny” the lessons that one learns from one’s own life experiences. However, the flip side of this coin is that psychiatrized people—like all people—can be led to very different ideological conclusions on the basis of their very different life experiences. As we will see in the next chapter, the tendency of social movement groups to disintegrate as a result of ideological incompatibilities can be traced back to the fact that compliance and non-compliance, writ large, do not mean the same things to everyone.
Chapter 7
The Tyranny of Categories: Sanism and Racism in Theory and Practice

1. “These People are Crazy.”

“Insanity is relative. It depends on who has who locked in what cage.” (Bradbury 1953: 137)

Snow, dirt, and road salt crunched beneath my shoes as I made my way down the street toward Ivy’s house, already twenty minutes late for a holiday gathering that she was hosting for a handful of Unhinged members. As I hurried through the upscale Richmond Hill neighbourhood, marvelling at the vast lawns and long driveways that lined her street, I could not help but worry about how Olivia, Ryan, and the others were feeling at that very moment. While I had only been attending Unhinged meetings for four months, I had already detected some clear interpersonal tensions, which tended to flare up whenever discussions turned toward the question of middle-class complicity in the psychiatrization of poor or indigent people. In particular, I noticed that Ryan seemed to target Ivy for critique during these discussions, a fact perhaps made inevitable by her ownership of both a house and a vehicle. While she was always pleased to drive anyone anywhere at anytime, and although several members regularly took her up on these offers, Ryan invariably declined the offers with demurrals that seemed tinged with more than a bit of annoyance (“I get it, okay? For the last time, I’m fine”). Ivy, a Hong Kong-born Chinese Canadian, was also one of only two non-white members of Unhinged, the other being Yashar, a Canadian-born Egyptian Arab, who attended meetings infrequently due to his busy work schedule and family commitments. Ivy, however, was the only member who did not speak English with native proficiency, although she was fluent in the language.

These were far from the only factors that set Ivy apart. Like the others, she never attended a meeting without bringing a spiral-bound notebook. Unlike the others, she spent most meetings studying from her accounting textbook, completing homework assignments, or compiling grocery lists rather than working on creative projects. Ivy was also the sole member who explicitly identified as “not political,” and she rarely contributed to political conversations. When she did, her contributions were not always welcomed. Once, during a discussion about a popular blog post entitled, “The Male Privilege Checklist,” she had challenged the prevailing tenor of the conversation with a question aimed at another female participant. “Do you even know how hard it is to be a man?” she had said. Before she could elaborate, she was shouted down by three other

---

108 The house actually belonged to her parents, who lived abroad, but she was its sole inhabitant (chapter 5).
participants: Ashley, Renée, and Ryan, who retorted, “When you learn some social theory, give us a call.” On another occasion, she sat tight-lipped throughout a discussion about women’s reproductive rights, and later told me that, unlike the others, she was “not sure” whether she agreed that abortion should be legal. In spite of incidents like these, the other Unhinged members generally treated her with civility and good humour, and she, in turn, lavished them with snacks and souvenirs from her periodic trips to Hong Kong. Ivy’s enthusiasm for the group nonetheless struck me as a bit odd in light of her disinterest in creative writing and dysfluency in political debate, and this incongruity was a source of profound confusion for me during the initial stages of my fieldwork. When I asked her what it was about Unhinged that appealed to her, she replied,

I just like having something to do. Do you know what I mean? I don’t know. It’s just, like, my thing. I’ve always been kind of weird, you know? It’s just a nice thing, when there’s, like, a group of people you can be yourself with and not care. I don’t know.

I later attempted to probe further by asking her how she first became involved in the group. Over coffee, she told me that she had discovered its existence in 2007 when she noticed a poster that had been taped to the interior wall of a bus shelter in the city, which advertised an arts-focused support group for psychiatric survivors and listed an email address. She sent an email expressing interest in attending the group (“I was just looking for something to do”) in which she had described herself as a psychiatric survivor who wanted to “meet other crazy people.” Olivia, who administered the Unhinged email account, invited her to join their meetings, and she quickly became a regular attendee. About half a year before my formal entrée into the group, Ivy had revealed to the other members that she had never actually seen a psychiatrist, been hospitalized, or taken psychotropic medications, because neither she nor her parents “believed in” psychiatry. However, she explained that she identified as a psychiatric survivor because her family doctor had diagnosed her with Obsessive Compulsive Disorder, and she had self-diagnosed herself with anorexia on the basis of medical books and online articles that she had read. According to other Unhinged regulars with whom I later spoke, including Olivia, Ryan, Alyssa, and Richter, this confession did not jeopardize her membership in the group. Olivia in particular was at pains to emphasize to me that they were an “inclusive” organization that saw psychiatry as the common adversary and that valued the contributions of every member—it was “not our place,” she stressed, “to tell people how to identify, as long as we’re on the same page about the shrinks.” Nonetheless, they acknowledged that they ceased referring to her as a fellow “psychiatric survivor” after this revelation. It seemed to me, moreover, that Ivy’s disclosure that she had never in fact set foot in a psychiatric ward, or consumed even a single psychopharmaceutical
capsule, served to set her even further apart from a core group of mostly white, working-class people with histories of psychiatric institutionalization and proclivities for creative writing.

As I stood on Ivy’s front porch that evening, clutching a plastic bag of seedless grapes and waiting for someone to answer the doorbell, I also found myself baffled by the group’s willingness to make the long trek out to the suburbs to spend time with someone whom at least one of them seemed to strongly dislike. I knew from prior conversations that Olivia was worried about the group’s racial homogeneity and I suspected that Ivy’s presence served to mitigate those worries. However, I had also been feeling uneasy about the way in which I was being perceived within the group, due to the fact that Ivy’s life and mine shared some superficial elements (we were both women of Chinese descent who had grown up in suburban York Region) and I was reluctant at such an early stage in my fieldwork to raise too many questions about the group’s internal dynamics. And so, in the weeks leading up to this night, I had tried to remind myself on a regular basis that there was much I did not know about Unhinged, its members, and their histories with each other, and was determined to try harder to suspend my judgements and apprehensions.

After a long wait, Ivy answered the door and let me in. I could hear animated chatter from somewhere inside the house. As I removed my shoes and coat, Ivy grabbed my arm and whispered furiously, “These people are crazy.” I looked at her in astonishment and asked what she meant. She waved her hand at the living room, as if to urge me to see for myself. As I approached, bits of the conversation became clearer and I paused to listen. Slowly, I realized that Ryan and Ashley were discussing the 1999 massacre at Columbine High School in Littleton, Colorado. In particular, Ryan was speculating about the role that “SSRI psychosis” might have played in the mass murder-suicide, in light of the fact that one of the gunmen, Eric Harris, had been on the antidepressant Luvox (fluvoxamine), which was found in his system during autopsy. Ryan argued that, while he was not attempting to “exculpate” Harris, it was “scientifically very probable” that the Luvox had exacerbated Harris’s feelings of resentment toward his peers, thus “pushing him over the edge” after years of bullying.109 I entered the living room and Ryan immediately pointed at me. “She’ll know,” he said. He looked at me. “Tell them. Tell them why SSRIs cause people to lose control,” he directed, taking me by surprise.

“I—I don’t really know much about that,” I sputtered, unprepared. It was true, at that time, that I had not yet encountered any literature on the causal relationship between

---

109 On April 20th 1999, Eric Harris and Dylan Klebold embarked on a shooting spree at Columbine High School, killing 13 people and injuring 21 others before committing suicide.
antidepressants and violent crimes, although I would later discover that this was a prolific area of discussion in the psychiatric survivor community. At that moment, my thoughts were centred only on the desperate hope to avoid being roped into what I knew was a contentious issue. Ivy, who emerged in an arched entryway on the opposite side of the living room, seemed visibly relieved that I did not intend to help Ryan defend a murderer.

Ryan seemed annoyed. “No, of course not,” he replied dryly. He followed my line of sight to where Ivy was standing and rolled his eyes. Ivy left the room. Olivia, ever the peacemaker, waved me over and redirected the conversation toward the considerably more benign topic of my teaching assistantship. The discussion about psychotropic drugs and uncontrollable violence was not revisited that night. Indeed, by the time we sat down to eat, it seemed as though the tense moment had been all but forgotten: the chitchat we all shared over dinner felt easy and free of controversy, and Ivy elicited supportive laughter from the whole table when she made a joke about her OCD. However, the tense moment had not been forgotten; as I later discovered, I had inadvertently slipped into the middle of a quarrel with a long history, which would ultimately prove fatal to the little community I had just joined.

Two months later, during a late February meeting where Ivy again rejected out of hand the notion that psychotropic drugs could make a person homicidal, Ryan had seemingly had enough. He pointed out that Ivy’s beliefs on this issue were not grounded in firsthand experience, and that her refusal to defer to the others in this matter was “sanist” and “a violation of the safe space” that Unhinged represented for psychiatrized people seeking a refuge from the stigmatizing judgements of society (“This is the one place in the whole fucking world—the one place!—where we don’t have to worry about self-censoring”). Ivy responded, as the others glared at her, by packing her belongings into her lavender tote bag and walking out the door. “Get some Zoloft while you’re at it,” he bellowed, invoking the trade name of an SSRI antidepressant that has been linked to several killings in the United States, including two school shootings (Kauffman 2009; see also Davey and Harris 2005), and that he himself had once taken. “When you know what you’re talking about, come back and we’ll talk.”

* * *

Donna Perry (2009: 35) has observed that events in which people “violate local codes of conduct” can provide an excellent window into the shared norms to which members of a given community subscribe. Using this insight as a launching point, this chapter analyzes a period of escalating tension between two key players in the Unhinged peer support group—Ryan and
Ivy—which culminated in the group’s disintegration and in Ivy’s total disavowal of the organized psychiatric survivor community. Throughout, I argue that their dispute had less to do with their clashing personalities than with their respective frustrations with negotiating a false sanity/madness dichotomy that structures both contemporary Mad Pride discourses and debates about criminal insanity. To contextualize Ryan’s intolerance of Ivy’s opinions—and of Ivy herself—I first review the rise of the 21st century Mad Pride movement, which concatenates “Madness” with intellectual endeavours that have historically been monopolized by white men, and which was nonetheless central to Ryan’s identity as a radical activist. Next, I show why and how the Unhinged group’s “safe space” policy, which was meant to safeguard members from the attitudinal policing they endured in mainstream society, was structured to disentitle Ivy from voicing disagreement on the one political issue she cared about: the notion that SSRI usage can cause violent murders. By then unpacking the specific SSRI-related tragedy over which Ivy and Ryan waged their final fight, and exploring the fight itself, I argue that seemingly sociopathic outbursts are often explicable in terms of predictable scripts (aggrieved masculine entitlement, eugenic paternalism toward the disabled, assumptions about Asian quiescence) in which we are all complicit: the “sane” at least as much as the “mad,” the “Mad” at least as much as the “sane.” I conclude by advancing some tentative hypotheses about the dearth of racialized participants in Western anti-psychiatry movements.

In the preceding chapters, I explored some of the thematic commonalities in my informants’ stories of psychiatrization and non-medical recovery, notable among which was the difficulty of explaining a transgressive life story to observers—relatives, psychiatrists, ethnographers—who may have a vested interest in sensationalizing some aspects of it while dismissing others. Psychiatrized people who decide on the basis of firsthand experience that the pain of madness is preferable to the pain of medicalization/medication, and who thus become “non-compliant” in secrecy, are striving to balance subtle costs and benefits that are typically not obvious to outsiders, such as the wish to mollify intrusive family members and appease clinicians and the wish to feel internally well. These individuals’ choices are nonetheless rendered invisible or inchoate by a mainstream narrative that equates “non-compliance” with inadequate “insight,” and insists that authentic recovery is impossible without professional supervision and biochemical intervention. As we saw in chapter 6, a recurrent feature of survivors’ stories was the revelation that biopsychiatry was doing them more harm than good.

110 Throughout this chapter, I use the adjective “Mad” to refer to the organized social movement that has arisen around this descriptor, and the non-capitalized adjective “mad” to refer to a general state of existential unruliness.
and an ensuing decision to quietly disengage from the psychiatric system: to feign gratitude, to
win freedom by playacting compliance, and to then slip through the cracks and never return. It is
consequently rare for physicians to learn about cases that challenge clinical lore about the
incurability of “serious mental illness” and, indeed, many doctors never discover that alternative
modes of recovery are feasible precisely because their former patients wish to cease all contact
with them. To borrow a phrase that Cassidy sometimes used when describing the challenges of
talking about Prozac with people who had never taken an SSRI antidepressant, “You can’t know
what you can’t know.”

This seemingly tautological observation conceals a deeper insight whose relevance
transcends discussions of biopsychiatric institutions: studying what is present and ignoring what
is absent yields only a partial picture of any given phenomenon. More specifically, while a
person’s quiet disengagement from a given enterprise can signify at least as much as another
person’s enthusiastic participation, it is much harder to observe and learn from the former; and
when the circumstances of a person’s disgusted departure from a group go unnoticed or
undocumented, that person’s perspective and his or her reasons for leaving can be wholly erased
from collective memory. Collective wisdom thus goes uncontested. In this way, the psychiatric
survivor community can suffer from some of the same blind spots as the psychiatric community.

Just as physicians fail to learn from survivors who slip through the cracks, activists can fail to
learn from each other when ideological incompatibilities lead some parties to withdraw or vanish
without explanation. Just as psychiatric survivors can find their actions trivialized with
descriptors like “non-compliant” and “insightless,” members of radical political collectives can
find their stories delegitimized with accusations of oversensitivity, unintelligence, or a lack of
streetwise credibility, all of which imply an unfavourable comparison with an ostensibly
authentic, ideal form of progressivity. As we will see, there is a category error at play in such
allegations, which assume that the targets of these accusations are striving toward and falling
short of an exemplary standard of dissidence rather than pursuing other priorities or aspirations.

As mentioned in chapter 3, Western anti-psychiatry has been in all of its incarnations an
overwhelmingly white social movement in which the chronic absence of racialized participants is
routinely noticed, lamented, and nonetheless left untheorized. This has been the case despite the
fact that some racialized groups’ historical maltreatment at the hands of Western psychiatry
would seem to make them natural candidates for anti-psychiatric mobilization (Mahone and
Vaughan 2007, Swartz 1995; see also chapter 3, section 2.2), and also despite white activists’
vocal solidarity with movements whose concerns have been racially shaped, such as prison
abolitionism and Black Pride. Whenever I asked my informants why they thought non-white psychiatric survivors were underrepresented in their community, I virtually always received the same answer: a grave acknowledgement that this was a longstanding problem and that white activists had to “reach out to” racialized psychiatric survivors, but very little in the way of an actual hypothesis. Toward the end of this chapter, I try to shed some light on this mystery by unpacking the priorities of two racialized members who quietly left Unhinged, and, in so doing, exercised “negative agency”—refusing “to use their bodily energies in the ways expected of them… for others’ social projects,” and critiquing an intolerable social structure by withdrawing from it (Wardlow 2006: 72; see also Wardlow 2002). In particular, I suggest that these two members experienced psychiatrization in ways that did not map onto standard definitions of psychiatric survivorship, and that their non-standard experiences were nonetheless shaped by structural and biographic variables that are common among racialized Canadians.

I could not, and would not, have written this chapter without the gracious support and encouragement of the two individuals I call Ivy and Ryan, both of whose feelings on the below events have become more nuanced in the two years since Unhinged dissolved. In all instances where I quote from electronic correspondence, I have done so with the authors’ explicit permission. Some of the contributors to the email thread I discuss in section 3.2 did not wish their words to appear in my analysis, and I have respected their preference. My provision of biographic context is limited in all cases to information that furthers the analysis but does not compromise participants’ anonymity. I would finally ask readers to bear in mind that “suffering… is a solvent of human integrity” (Bourgois 2003: 15), and that enraged reactions that appear disproportional to perceived offences often reflect invisible hierarchies of symbolic and cultural capital that transform seemingly offhand remarks into intolerable insults (e.g. Ivy asking Ryan one too many times why he doesn’t have a driver’s licence; Ivy being told one too many times that she doesn’t understand social theory). Additional thoughts on the ethical implications of focusing on ideological disputes in anti-psychiatry can be found in the section entitled “Ethnographer or Voyeur?” in chapter 2.

2. Madness, Sanity, and the Problem of Volition

2.1 Getting Mad: Anti-Psychiatric Politics in the Mad Pride Era

Sources generally agree that the Mad Pride movement originated in the late 1990s in the United Kingdom, sparked by a 1997 government proposal to celebrate the 750th anniversary of the founding of Bethlem Royal Hospital—the infamous Bedlam asylum (Crossley 2006: 205,
Perring 2009: 6, Shaughnessy 2000: 20-22, Survivors’ History Group N.d.). In May 1997, outraged psychiatric survivors took out an advertisement in the U.K. *Survivors Speak Out Newsheet* under the name “Reclaim Bedlam,” stating that “we find the whole idea of ‘celebrating’ the history of Mental Health offensive… It’s our history and we should mark the 750th anniversary with our voice” (Crossley 2006: 204). The Reclaim Bedlam organizers marked the occasion with a rally meant to “acknowledge our survival and to call for the abolition of psychiatry and the destruction of mental health institutions and the professional and commercial interests who benefit from them” (Crossley 2006: 204). In September 1997, a little over a month after London’s Gay Pride march, suggestions for Mad Pride events began appearing in the *Survivors Speak Out Newsheet*, and survivors who had been involved in Reclaim Bedlam began calling for the reclamation of the traditionally pejorative term “mad” in the same way that gay and lesbian activists have reclaimed the term “queer” (Crossley 2006: 205; see also Glaser 2008: para. 6-7). In 1998, 45 out of 92 respondents to a questionnaire published in *Survivors Speak Out* voted in favour of organizing under the umbrella term “Mad Pride” (other suggestions included “Mad Power,” “Glad to be Mad,” and “Positively Mental,” Perring 2009: 8). In October 1999, the first Mad Pride events were held in the United Kingdom.

Despite the centrality of U.K. activism in the rise of Mad Pride, the first documented application of the “Pride” framework to psychiatric survivorship actually took place in Toronto in 1993, when survivors and their allies organized an event to challenge the prejudices of residential associations that had been opposing the establishment of affordable housing programs for discharged inpatients in their neighbourhoods. The name of the event, “Psychiatric Survivor Pride Day,” was selected to convey the message that “Psychiatric survivors are part of the community and belong here just like anyone else,” notwithstanding the objections of some organizers who did not want to be associated with the LGBTQ community (Reaume 2008: 2). On September 18th 1993, one hundred participants marched from the Parkdale Library to what was then the Queen Street Mental Health Centre (now the Centre for Addictions and Mental Health, or CAMH), laid flowers at the foot of the western boundary wall,111 and attached a list of names of people who had died in mental institutions (Reaume 2008: 2-3). Scaled down versions

---

111 As recently as 1996, a Toronto Heritage property report listed the builders of the CAMH boundary walls as “none found”—however, these walls were actually constructed by unpaid psychiatric patients in the late 19th century, saving the then-Toronto Hospital for the Insane “tens of thousands of dollars” in wages (Reaume 2009: 147; see also Reaume 2007). The centrality of patients’ unpaid labour to the operation of the Hospital throughout the 19th and early 20th centuries was formally recognized in September 2010 with a series of memorial plaques around the CAMH perimeter (a project that was initiated and chiefly funded by the Psychiatric Survivor Archives of Toronto).
of Psychiatric Survivor Pride Day were also held in 1994, 1995, and 1997, although marches were again organized for the 1998 and 1999 events. In 2000, Torontonian organizers decided to align the date of the event with that of Mad Pride Day, which had come to be celebrated by psychiatric survivors in Europe and the United States on Bastille Day (July 14th) in recognition of the fact that some of the prisoners freed during the French Revolution’s opening stages had been mental patients (Morrison 2005: 143, 166). In July 2001, activists on both sides of the Atlantic coordinated their protests under the name, “International Mad Pride Month” (Survivors’ History Group N.d.). In 2002, Toronto’s organizers permanently switched over to the “Mad Pride” terminology, and Mad Pride Week has since taken place in this city in July of each year.

Two Mad Pride Weeks took place during my fourteen months in the field. The first was billed as “a festival of arts, education and heritage activities which recognize psychiatric survivors, consumers, mad folks and others for the purpose of community development, rights awareness and celebration” (Mad Pride Organizing Committee 2009: 2). The second was billed as “community events and a strong and tenacious movement to celebrate, educate and recognize achievements, honouring our past with reclaiming our MADNESS … because we’re proud to be mad” (Mad Pride Organizing Committee 2010: 1). Both consisted of a weeklong series of lectures, films, theatrical performances, and guided tours of CAMH’s patient-built boundary walls, all of which were widely attended by both psychiatric survivors and mental health professionals. In spite of—or perhaps because of—Mad Pride’s decade-long stature as an annual, international event that is open to all participants, political fissures and factions have begun to emerge within the psychiatric consumer/survivor/ex-patient community with regard to both the “Mad” and the “Pride” aspects of the framework. As alluded to above, the fact that “Pride” was initially borrowed from the LGBTQ struggle has been problematic for Mad activists who either object to being linked to another stigmatized identity, are homophobic, or object to the appropriation of the queer community’s representational tools (sometimes because they themselves are queer, and they reject the analogy that the phrase “Mad Pride” tacitly draws between the two dimensions of their identity).112 As one interviewee, a gay man in his twenties who had been hospitalized as a teenager following a suicide attempt, pointed out to me, “A

---

112 It should also be noted that the “Pride” framework is not uncontroversial within LGBTQ communities either, and has been critiqued for, among other things, implying that all queer people are bonded by a common political outlook, and falling prey to increased commercialization in recent years (Fox and Ore 2010; Kates and Belk 2001). Marc Edelman has also observed that a major risk of mobilizing around “diversity” frameworks is that such efforts easily become “fodder for lucrative corporate marketing crusades [that] absorb identity imagery of all kinds in order to peddle ‘mono-multiculturalism’ across myriad differentiated markets” (2001: 300).
straight cisman in a psych ward is not going through what a lesbian transwoman in a psych ward is.” A transgender activist with whom I spoke expressed discomfort with the Mad Pride movement’s implicit acceptance of “craziness” as a kernel of personal identity, explaining that it undermines transgender and transsexual people’s efforts to avoid pathologization in daily life: “Do you know how hard it is to convince people you’re not crazy when there’s a huge movement that says, ‘we’re proud to be crazy’? What I’m proud of is being a normal, sane person trying to live a normal life in a culture that keeps telling me I’m sick and abnormal.”¹¹³

An additional source of tension is the word “mad” itself, which is richly polysemous and comprises a wide range of possible meanings. To describe oneself as “mad” rather than “mentally ill” may be to express solidarity with the organized Mad community, but it can also be an isolated act of humour or provocation; a way to convey the ferocity of one’s internal feelings without necessarily meaning to ally oneself with the Mad Pride movement; or a way to discuss one’s condition without having to assume the surplus burdens of medicalized language (e.g. “I went mad,” as opposed to “I became mentally ill”). As one Torontonian survivor has put it, “I prefer to refer to myself as ‘Mad’ because it is a term that I have chosen for myself. It is not a diagnosis that a doctor has given me like depressed or bipolar … Choosing the term ‘Mad’ makes me feel powerful because it lets me know that I can be in control of what words are used to describe me” (Reid 2009: 4). There are nonetheless some commonalities to the diverse meanings that people assign to the adjective. When I solicited definitions from my informants, I discerned at least three main contentions underlying their litany of suggestions: that madness was clearly distinguishable from sanity/normalcy, that madness and artistic creativity were inherently linked, and that identifying as Mad entailed the freedom to simply “be” or “just be me.”¹¹⁴

Below are ten people’s responses to the question, “What does being ‘mad’ mean to you?”

- **Being free to just be me**, to do my own thing.
- Moving through the world in a body that the medical establishment defines as non-normal.
- Being part of an amazing community that doesn’t say things like, “We’re not crazy.” We are crazy!

¹¹³ In recent years, transgender activists have campaigned to have Gender Identity Disorder (GID) removed from the DSM, asserting that “gender identity and expression that vary from assigned birth sex are not, in themselves, grounds for diagnosing a mental disorder” (Wingerson 2009: para. 2), and recapitulating some of the arguments that gay activists successfully deployed in the 1970s to compel the American Psychiatric Association to remove homosexuality from the DSM. The effort to de-medicalize transgender and transsexual identities acquires particular urgency in light of the fact that medical professionals currently serve as gatekeepers of vital biopharmaceutical resources (e.g. prescriptions for hormones and hormone blockers, referrals for genital reassignment surgeries) without which many transpeople are consigned to lifelong anguish and dysphoria. In other words, transpeople are currently required to accept a mental illness label in order to access resources that are, for them, lifesaving.

¹¹⁴ Indeed, as I recently discovered, this theme is expressly embedded in the slogan of Mad Pride Toronto 2012: “The right to be free... The right to be me.”
• **Having to deal with sanist bullshit bigotry** all the live-long day.
• Following in the footsteps of crazy kids like Beethoven, Schumann, and van Gogh.
• Living with a dangerous gift. I would never choose to be normal.
• Out-of-control, anarchic, wild-child anti-establishmentarianism.
• Just having the **freedom to say and be and do and want what I want, to be who I am.**
• Rejoicing in **not having to go through life as a mundane** [a pejorative for non-psychiatrized people].
• Sex, drugs, and rock n’ roll. **Fuck normality.**

All three of these themes are interleaved in the excerpt below from an essay in the winter 2009/2010 *MindFreedom Journal*, which was authored by prominent Mad activist John McCarthy:

The word madness has been stolen and perverted into something to be afraid of. You see, the mad community is the most peaceful, loving and caring section of the total community. **We are the people who give you music, art, poetry, playwrights, actors, musicians and yet despite these gifts society chooses to persecute us.**

There is no doubt that we who are mad are different. It is how you treat that difference that is the issue at hand... **It is your call: Embrace us for our difference rather than reject us. Your lives and ours would improve so dramatically.** As it was and is with all human rights campaigns, we in the mad community, if we are ever to gain a place of equality and dignity within the general community, have to lead this call for our human rights ourselves. ... If we are to become equals in this society, then we of the mad community have to stand up and say, ‘I am mad and I am proud.’ **You of the so-called ‘sane’ community have to embrace us...** Allow us to be different, to celebrate our difference for what it simply is, just that, **DIFFERENCE** (McCarthy 2009/10: 7).

This impassioned exhortation erects a clear boundary between “us” (creatively gifted “mad” people who are seeking the freedom to be themselves) and “you” (“sane” people who persecute but benefit from creatively gifted “mad” people). Allusions to creatively gifted historical figures who are said—or speculated—to have suffered from forms of madness indeed appear with great frequency in Mad Pride materials, and, to be sure, such allusions serve as efficient counterexamples to the stereotype that “mental illness” is always a liability and never an asset. It was precisely for this reason that Ryan, who strongly disliked the psychiatric survivor identity label (see chapter 5), much preferred the Mad identity label, which he sometimes used interchangeably with the term “anti-psychiatry.” On two separate occasions, when I absent-mindedly used the words “unreasonable” or “volatile” in his presence (specifically, “I think the whole situation is unreasonable” and “His roommates say he’s volatile”), Ryan cut me off and encouraged me to examine the “sanism” embedded in each sentence. His objection was that each phrase expressed a moral judgement that, in concert with other such judgements, undermined the Mad community’s efforts to rehabilitate the complex of words, tropes, metaphors, and other semiotic resources that underwrote the concept of “being crazy.” As he put it,

What we’re not wanting to do is be like, ‘You can be crazy and still good or smart’ or whatever. It’s just one of those things that you can’t separate it and say one is this and the other is that. You have to think in terms of, like, Kurt Cobain wasn’t brilliant in spite of being depressed, he was brilliant because he was depressed, no difference. It’s not just talk. Okay, you know how you would never say, like, ‘You throw like a girl,’ cause we all know how fucking sexist that is. [Similarly] it’s sanist, always only using things like
McCarthy and Ryan both raise trenchant insights about our society’s tendency to speak of “mental illnesses” as categorically undesirable and somehow separable from the people who experience them (see chapter 4). However, romanticizations of creative madness rely on a few assumptions that are not applicable to every “mad” person: madness is not always a source of artistic virtuosity, and the creative oeuvres of the various artists invoked in the preceding Mad discourses—Beethoven, Schumann, van Gogh, Cobain, Cohen, Hemingway—were made possible only by substantial investments of time, labour, equipment and patronage that are available only to an elite minority. Moreover, not once did I personally hear anyone name a non-white, non-male artist or writer as an illustration of Mad virtuosity. This does not mean that racialized and/or female artists are never invoked in support of Mad Pride (Jamison 1993 lists several such examples, and her book has become a staple in the Mad community). However, it is noteworthy that the names that my interviewees spontaneously cited were all those of white men, a point to which I will return later.

Romanticizations of madness also elide the fact that safely identifying as “mad” or “crazy” is a privilege to which not all psychiatrized people have access. As Tanya Luhrmann (2007, 2008) has persuasively shown, homeless women who adamantly refuse to identify as “crazy” are not lacking in “insight,” as their clinicians believe—nor are they engaging in sanism or disavowing the Mad political subjectivity, the existence of which is immaterial to their daily lives. The reason why Luhrmann’s informants strenuously insisted that they were “not crazy” and thus refused to avail themselves of social services reserved for the psychiatically diagnosed was quite straightforward: the prevailing belief on the street is “that the strong and determined will withstand but the weak and feckless will become crazy,” and these women wished to avoid openly situating themselves on the latter end of the spectrum (Luhrmann 2008: 16). To proudly identify as “mad” or “crazy” in homeless shelters and on the street would be both to invite physical violence and victimization, and to accept an identity label that in their world is a synonym for the permanent loss of hope. As one of Luhrmann’s informants announced, “I am a person… who would NEVER allow myself to go crazy,” even though she herself lived in psychiatric housing (Luhrmann 2007: 161; emphasis in original).

These epistemological conundrums have not gone unnoticed in the broader psychiatric survivor/Mad communities. Although many psychiatric survivors support Mad Pride’s empowering connotations and enthusiastically participate in the yearly festivities, others reject...
the framework. Reasons for some survivors’ rejection of a “Mad” identity range from wanting to wash their hands of prominent members of the Mad Pride movement, to not wanting to delegitimize themselves in the public eye by identifying with a term that is a synonym for “irrationality” in common usage. In his interviews with survivors who had been politically active in the 1980s, Nick Crossley indeed found that many activists of the older generation were wary of valorizing madness, and more than a few “expressed a view that the stigmatization surrounding ‘mentality’ necessitated that the protestors present a very rational face to the outside world” (2006: 207). I encountered similar sentiments in my own interviews (e.g. “You’re mad—fine—you got locked up. That is not what happened to me... By no means was I mad,” see chapter 3). Some Mad activists also refuse to identify as psychiatric survivors out of a desire to disassociate from prominent psychiatric survivors; others do so either because they have never experienced psychiatric treatment firsthand or, in some cases, because they do not want to allow psychiatrists to be the gatekeepers of the “Mad” collective identity. In the same way that “Gay Pride” is presented in the mainstream as an assertion that non-heteronormative sexuality is nothing to be ashamed of, Mad activists likewise assert that there is no shame in being “mad,” “crazy,” or “insane,” and that it is in fact a form of bigotry to claim otherwise (“sanism”).

For this reason, advocates of Mad Pride have often been “critical of what they perceived to be the timidity, self-pity and political incorporation of their predecessors” (Crossley 2006: 207). As the editors of an influential anthology entitled Mad Pride: A Celebration of Mad Culture claim,

Engaging with government commissions and planning groups is all too often a way for survivors’ views to be absorbed into bureaucratic systems, only to be rendered powerless. It is hardly surprising that a growing number of survivors operating in the “user movement” now feel that direct action is the correct way forward: defiant displays of ostentatious madness; riots; sabotage; medication strikes; and linking up with those elements who wish to bring about a complete transformation of society. ... Much of the literature around mental health has focused on the ‘victim status’ of mad people. This book, on the other hand, celebrates madness largely from the perspectives of users who refuse to be ground down. It asserts the rights of ‘mad’ people without pleading for them, in the belief that we should not push meekly for minor concessions, but instead change the world into a fit place for us to live in (Curtis et al. 2000: 7-8).

The clear contrast the Curtis et al. draw between the goals of Mad Pride and the goals of other iterations of survivor/consumer activism closely mirrors Lenny Lapon’s critiques of his professionalized colleagues (chapter 3) and, more generally, the broader debate within 1980s anti-psychiatry that ultimately led to the movement’s fragmentation: whether policy reforms

115 For example, after being lectured by a prominent spokesman in Toronto’s Mad community for using the word “mad” too liberally in daily conversation, one of my interviewees decided to quit a particular organization in disgust. He no longer identifies as either “Mad” or as a “psych survivor,” although he used to identify as both.
suffice, or whether activists need to militate with greater vehemence against the whole of an injurious social polity. As noted, the romanticization of “ostentatious madness,” “out-of-control, anarchic, wild child anti-establishmentarianism,” and eccentric bohemianism that is integral to much Mad Pride messaging can present an ethical dilemma for activists who wish to convey both that (1) madness is “the only available response to an obscene system” (Curtis et al. 2000: 8) and that (2) madness is a desirable, creatively fruitful state of being. Christian Perring has noted that

many people with serious mental illness do not take pride in having what they see as a disabling disease, and they want to be rid of their condition. Some have objected to the Mad Pride movement on these grounds. So the movement raises questions of whether it makes sense to make an analogy with Black Pride, Gay Pride, or pride in being a woman, since being black, gay, or a woman are not conditions that are inherently disabling, even if in our society, they can put one at a disadvantage (2009: 7).

It is, of course, vital to acknowledge that madness is painful and that pain can impair creativity and insight; at the same time, there is no necessary contradiction between these assertions and the assertion that pain can also unlock insights that are not available to the comfortable and content (see Jamison 1993, Martin 2007). The rationale behind the Mad movement’s apparent romanticization of desolating distress become clearer when we sever the link between pain and pathology. By positioning themselves as the latest in a long lineage of “pride” movements, Mad Pride activists are arguing that while recipients of psychiatric labels may appear disabled, the disability does not inhere in their bodies/brains but instead results from a disabling society. That is, to fail to go mad while subject to the depredations of “an obscene system” would be to deviate from the norm; to go mad under obscene conditions is to respond as expected. The subtle equation of madness with mental health is evident in the below excerpt from a biographic essay written by a prominent U.K. Mad Pride activist, which Richter used as the wallpaper (desktop image) on his personal computer:

I was always mad because I never wanted to be part of the shitty straight world—what kind of pervert actually wants to go out to some job they hate day after day, kneel to a boss they hate, buy the right car/right clothes/right computer/right CDs and still feel empty? Fuck that con! (Morris 2000: 207; emphasis mine)

This writer raises important questions about the constructedness of consumerist lifeways, and he rightly draws attention to the alienating nature of much wage labour. Nonetheless, his suggestion

---

116 The revival of this debate over the past decade did not take place in a cultural vacuum. Just as each of the previous decades’ iterations of anti-psychiatry mapped onto trends in neighbouring social movements on the Left, the rise of Mad activism in the late 1990s/early 2000s was strongly shaped by the ascendance of an international anti-globalization movement (catalyzed by widespread outrage about free trade agreements that disadvantaged local economies, and epitomized by the November 1999 demonstrations against the World Trade Organization Ministerial Conference in Seattle) and the revitalization of an antiwar movement following the events of September 11th 2001, the invasion of Iraq in March 2003, and all of their attendant consequences for civil society at home and abroad.
that it is perverted to desire such a life seems to rely on a cardinal premise of psychiatric logic: that some desires are inherently irrational and in need of rehabilitation, regardless of the desirer’s feelings on the matter.

While inconsistencies indeed appear to proliferate when Mad Pride messaging is evaluated as a monolithic whole (e.g. going mad is normal, but being abnormal should be a source of pride, which means that *not* going mad should be a source of pride, and so on), it is useful to understand these semantic frictions not as logical contradictions per se but, rather, as an indication of the ideological and metaphorical heterogeneity of the “Mad” rubric, and a hint of a deeper tension in Mad discourses: a heavy reliance on binary logics that routinely conceal as much as they reveal. Examples are visible throughout a recent keynote speech delivered by David Oaks, the Executive Director of MindFreedom International, who asserted that

*For centuries there has been a war between those called “normal” and those called “mad”*… When people are unfairly divided by skin color, that racism causes trauma. When people are unfairly treated because of gender, that sexism causes suffering. But humans often define ourselves as the thinking or rational animal. The *minority of us perceived as irrational is considered inferior in our most basic essence—our chemistry, our genes*.

Have you all heard it? It is sanism. Sanism has a long history. … It is revealing that it was mainly in the fairly recent 1800s that the huge psychiatric institutions were first built. For better or worse, the Western world was eager to urbanize, colonize, industrialize, globalize. What to do about us eccentric citizens who do not fit in the Great Globalization? Country folk who spout bizarre beliefs? Joan of Arcs when they have no army? Witches? Head injured? Fools? Developmentally disabled? Shamans? In the 1800s we strange others on the margins were seen as impediments in the great rationality.

The extreme of this oppressive approach can be seen in how those of us given psychiatric labels were treated in Europe. In the 1930s, Nazi Germany targeted children diagnosed with mental disabilities as the very first group for mass murder. Psychiatrists helped develop the theory, methods and even the paperwork used in Nazi genocide. Never forget. Never again (Oaks 2010: 5; paragraphing maintained from official transcript of speech; emphases mine).

On the one hand, the comparisons that Oaks draws between sanism and other forms of lethal prejudice are timely and important: it is sometimes forgotten that psychiatric patients were among the first constituencies targeted for extermination in Nazi Germany, and it is true that “strange others” who violate arbitrarily normative behavioural codes have faced not only social ostracism but incarceration, exile, and death throughout history. On the other hand, the speaker’s contraposition of racism (“causes trauma”), sexism (“causes suffering”), and sanism (directed against a “minority of us perceived as irrational… considered inferior in our most basic essence—our chemistry, our genes”) implies, firstly, that each form of prejudice can be neatly pruned off from the next, and, secondly, that sanism is not only separable but somehow worse as it is targeted at a more basic level of a person’s embodied existence.

The clean lines between sanism and other -isms that appear in this excerpt are not unique to this speech, and I do not mean to single out Oaks for critique. As I will explain in the
remainder of this chapter, it is precisely the ubiquity of these discursive moves in the Mad and psychiatric survivor/consumer communities that are alienating to participants for whom psychiatrization is not meaningfully distinguishable from, for example, racialization. When viewed from this angle, however, the reasons why racialized constituencies have been under-represented in anti-psychiatry movements since their earliest incarnations in the 1960s become somewhat more apparent. The fact that “our [the North American anti-psychiatry] movement has failed to attract black people and other people of colour” (Weitz 1983: 14, PR, see chapter 3) can be understood in terms of a selection bias: racialized people do not necessarily identify psychiatry as the primary source of their abjection—even if it is one such source—nor do they necessarily see resistance to psychiatry as their primary avenue to liberation, and they may wish to reserve their dissident energies for other struggles (Diamond 2012). In addition, they may see the “anti-psychiatry” that is articulated by white activists as not only inadequately attuned to the injustices that mark racialized people’s lives, but directly complicit in them. An analogy from the experiences of racialized women who disavowed mainstream Western feminism in the 1980s is instructive here. As Canadian anti-racism activist Renee Martin has put it,

I’m not a feminist (and there is no but), because my life experiences lead me to believe that feminism was not created for women like me. The name of the first feminist hero mentioned by my professor in my first women’s study lecture was Simone de Beauvoir, and the trend of focusing on white women would continue throughout my education. Inclusivity to the women’s studies department that I was a part of meant using the work of bell hooks occasionally. However, she quickly became an additive, thrown in to give the appearance of intersectionality. I would have to scour the library and online journals to learn names like Patricia-Hill Collins, Audre Lorde and the woman who would become my inspiration, Alice Walker. And so I followed indexes and bibliographies, desperate to read journeys that mirrored my own.

I sat in seminars where I became the “token black woman” when they deemed it necessary to actually consider something outside of the white woman as monolithic representative. Despite feminism supposedly being a movement to end women’s oppression, women’s studies seminars and lectures are… where I learned that the sisterhood and camaraderie lasts only as long as you don’t insist on interrogating oppression from multiple sites (Martin 2010: para. 3-4; emphases mine).

In the above excerpt, Martin describes her slow, alienating realization that she was valued solely for what she could do for a political movement (e.g. serving as a “token” minority presence to confer an appearance of diversity) and not for what the political movement could do for her. Her educational priorities received no institutional support, becoming a solitary quest for writings that spoke to her, and she experienced her women’s studies program not as a site of liberation but as a stressful space in which her classmates’ and instructors’ illusion of “sisterhood” took precedence over her input. Martin’s words eloquently capture an experience that is analogous to that of many psychiatric survivors: as we saw in chapter 6, the causes that a person attributes to their pain will have clear implications for what route to “recovery” makes sense to them,
requiring survivors like Cassidy and MacDaniel to take charge of their own political educations and “scour the library… desperate to read journeys that mirrored [their] own.” But it is precisely this parallel that throws into sharp relief the dilemma of racialized activists in predominantly white movements: just as psychiatric survivors must keep their grievances to themselves if they wish to preserve family harmony and avoid forcible intervention, racialized people must keep their grievances to themselves if they wish to preserve group harmony and avoid exhausting arguments. Thus, if psychiatrization is frequently an endpoint of accumulated oppressions (chapter 5) and if madness is a natural “response to an obscene system” (Curtis et al. 2000: 8), the space that separates resistance against “sanism” and resistance against racism, sexism, heterosexism, classism, etc, may be slim indeed.

In a thoughtful analysis of infighting within LGBTQ campus communities, Fox and Ore (2010: 631) point out that “efforts to challenge one form of oppression often unintentionally contribute to other forms of oppression.” During the process of planning a national conference on queer activism, student organizers at Fox’s university became angrily alienated from each other, due in part to gay white male organizers’ insistence that the target of anti-gay bigotry is “gayness” and that other marginal identities (e.g. blackness, femaleness) must not take centre stage at the conference. In the end, although the conference did take place, several members of the steering committee felt compelled to resign beforehand and the organized campus queer community ultimately dissolved. Fox and Ore (2010: 632) observed that a cardinal problem during the planning process was some organizers’ apparent assumption that identities are experienced in “an additive manner,” and that “all gay people experience homophobia and heterosexism in similar ways.” Because society at large has accepted this assumption, a certain iconographic shorthand has developed around the juxtaposition of “pride” and “shame,” whereby the oppressed-but-proud individual is always tacitly a white man who defiantly refuses to relinquish prerogatives that are rightfully his (Halberstam 2005). Such images erase the experiences of white women and racialized men and women for whom “shame” often consists in a daily pageant of slights and indignities that are too voluminous and too subtle to effectively challenge, and that belie the false intimacy of umbrella terms like “Gay Pride” or “Mad Pride.” In order to access the nuanced manner in which dignity and humiliation play out in people’s lives, “we need an analytic tool that does not simply result in a catalogue of difference, nor only imply (as patriarchy, dominance and heteronormativity do) a simply dichotomous model of inequality” (McElhinny 2003: 258; italics in original)—a point that is equally applicable to analyses of psychiatric reasoning that draw too heavily from a “madness/sanity” dichotomy.
In *Madness Network News*’s dying days, editor Morgan Firestar (1986: 3) reproached her colleagues for presuming that they had “the right to decide which groups and/or individuals are ‘legitimate’ members of the anti-psychiatry movement” by holding them to predetermined ideological standards. Firestar’s admonishment raises an important question in light of the foregoing discussion. On what basis do some psychiatrized people get to police the identities of other psychiatrized people? What factors confer political credibility upon some and strip it from others? As we will now see, the formalization of collective identities—and “safe spaces”—based on experiential binaries (e.g. whether or not one has been hospitalized, whether or not one has taken medication, whether or not one has received a diagnosis or even consulted a medical authority) creates a dilemma for people who suffer from forms of psychiatrization that are not officially documented or medically recognized. Ironically, the authority of institutional biomedicine can thus reign supreme even in communities that nominally reject it.

### 2.2 The SSRI Revelations: From Missing Link to Groupthink

In 2004, the U.S. Food and Drug Administration convened a series of public hearings after receiving multiple complaints of alarming side effects from antidepressant users. Patient and professional testimony at these hearings revealed that “there was a doubling of the risk of suicidal activity on active drug treatment compared with placebo” in youth and adolescents (Healy 2006: 76). In September 2004, the FDA formally required drug manufacturers to package antidepressants with a label warning of an increased risk of suicidality in users under 18 years of age; in December 2006, the FDA extended this warning to include users aged 18 to 25. The FDA (2005: 2) now cautions on a report posted to its website that:

> anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications… there is concern that such symptoms may represent precursors to emerging suicidality.

---

117 Drug manufacturers have complied. As Pfizer warns about its antidepressant Effexor XR, “Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, teens, and young adults. … Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior” (Pfizer Inc. 2011: para. 1).

118 Suicidality has also been identified as a potential outcome of psychotropics other than antidepressants. In January 2012, an FDA advisory committee recommended that the label of a popular ADHD drug (dexamfetamine, trademarked as “Focusin” and “Attenade”) should warn consumers that suicidal thinking is a known side effect (Yukhanov 2012). In addition, a September 2012 *Toronto Star* report reviewing ten years’ worth of adverse reaction reports submitted to Health Canada notes that in “more than 40 per cent of all where a youth thought about suicide, an ADHD drug is listed as the suspected cause” (Bruser and Bailey 2012: para. 42). The *Star* report, however, neglects to mention that the *Star* itself is a major purveyor of the notion that many children have undetected mental disorders like ADHD, which encourages parents to have their children diagnosed and medicated (see chapter 4, plus Helen and Matt’s story in chapter 6).
Health Canada has issued similar advisories about “SSRI and other antidepressants,” warning that the drugs are linked with “the potential for behavioural and emotional changes, including risk of self-harm” (2004a: para. 1, 2004b: para 1). Specific warnings for suicidality are posted on Health Canada’s website for the SSRI compounds Paxil and Zoloft (2004a, 2004b; see also 2004c) as well as the NDRI antidepressant Wellbutrin (2003d). Over the past decade, due in part to a growing number of online communities and memorial websites for former, withdrawing, or deceased SSRI users (e.g. www.paxilprogress.org, www.ssristories.com, www.theeffexoractivist.org, www.break-the-silence.org, www.thesaveproject.org, www.injuryboard.com, www.crespifamilyhope.com), it has become widely accepted within North American psychiatric survivor communities that SSRI antidepressants alter users’ volitional capacities in a way that may lead them to commit violent acts. One of these sites indeed contends that 66 school shootings and knife attacks between 1995 and 2011 were perpetrated under the influence of antidepressants, including Eric Harris’s assault on his classmates at Columbine; this claim is documented in a chart that is viewable at www.ssristories.com/index.php?p=school. While some researchers (e.g. Wessely and Kerwin 2004) have argued that these incidents represent perpetrators’ underlying depression overcoming their medications’ suppressive powers, Kauffman (2009: 11) has recently pointed out in the Journal of American Physicians and Surgeons that, in published studies comparing SSRIs with placebos, “[c]hildren diagnosed with OCD, not depression, also became suicidal on SSRIs, as did healthy volunteers.” Moreover, clinical trials cannot be expected to demonstrate clear empirical links between SSRIs and homicide given that no institutional review board would ever approve such a study (Kauffman 2009).

Recent studies do, however, document strong correlative, although not necessarily causal, linkages between SSRI usage and precursors to violence like aggression, self-harm, hostility, paranoia, and impulsivity, in addition to suicide (Fergusson et al. 2005, Wooltorton 2003). For example, in a review of seven hundred randomized controlled trials, Ferguson et al. (2005: 400) “documented a more than twofold increase in the rate of suicide attempts in patients receiving SSRIs compared with placebo or therapeutic interventions other than tricyclic antidepressants.” In 2005, Wyeth Pharmaceuticals (now owned by Pfizer Inc.) added “homicidal ideation” as one of the rare adverse effects119 of its popular SSRI antidepressant Effexor (Brown 2006). Concerns about such findings have also begun to creep into the mainstream media: in September 2012, it

119 Defined by the U.S. Food and Drug Administration as an effect with a < 1 in 1,000 occurrence rate.
was reported in the British newspaper *The Guardian* that GlaxoSmithKline had fudged its clinical trial data for its top-selling antidepressant Paxil by combining its data from trials in children with that of trials in adults, a vastly larger participant pool, meaning that “any sign of increased suicide risk among children on paroxetine had been completely diluted away” (Goldacre 2012: para. 28). And, in September 2011, as reported in the *Winnipeg Free Press*, a Manitoba judge made the unprecedented ruling that a Winnipeg teenager was driven to commit murder because of the adverse effects of Prozac. Judge Robert Heinrichs asserted in a written statement that the teenaged boy’s “mental deterioration and resulting violence would not have taken place without exposure to Prozac,” and that, now that he is off the drug, he “no longer poses a risk of violence to anyone” (quoted in McIntyre 2011: para. 4).  

In the months and years following my fieldwork, stories and studies about SSRIs’ link to irresistibly violent urges became impossible to ignore, and I eventually came to understand why Ryan had been so certain during the debacle at Ivy’s house that my sympathies would rest with him. I would soon learn—albeit not soon enough—that many local psychiatric survivors treated the link between SSRIs and compromised volition as so well-known, and so well-established, that no educated person could deny it. Indeed, this link was sometimes *assumed* rather than *asserted* during conversations. For example, while speaking with a long-time survivor activist in the summer of 2010, the question of how I first became aware of psychiatry’s influence throughout society arose. I mentioned that, while attending elementary school in the 1990s, I had noticed that some of my classmates were on prescription antidepressants or psychostimulants, which they consumed in the middle of the school day during the lunch hour. At this point, I had planned to say simply that such observations had taught me to see behavioural trouble as something that was medicinally suppressible. But before I could verbalize this thought, the activist cut me off and tried to finish the anecdote for me: “Gosh, poor things. I have friends who killed themselves on SSRIs too.” This was not the intended ending of my story. Yet, while the conclusion to which she had instantaneously leapt surprised me, it escaped my notice at that time that her assumptions undercut objections to psychiatry that were not linked to drugs’ adverse effects. In another revealing incident, Sheila (of Folie à Deux) began speculating about how her son Julian’s adolescence might have unfolded if she had followed his pediatrician’s suggestion

---

120 The accused, who had no prior history of violence, had been prescribed Prozac three months prior to the homicide. When his parents complained that his behaviour was becoming odd and erratic, his doctor *doubled* the dosage. Seventeen days later, the victim visited the accused’s residence at a time when he was not home and got into an argument with the accused’s younger brother. The victim then shoved the brother into a chair, which fell over and scratched the new floor; when the accused came home and discovered what had happened, he invited the victim back to his home and stabbed him. Immediately afterward, he called the police (see Breggin 2012, McIntyre 2011).
that he take antidepressants “to stabilize” his moodiness. “Oh, that’s easy,” Julian interjected, before his mother could develop her theory further. He then jokingly pantomimed hanging from a noose, to the grim nods and chuckles of the older adults gathered around the table. Yet another recent interaction exemplifies this pattern: in recent news coverage of a murder trial in which a Canadian woman, Felicia Boots, pleaded guilty to killing her two children while living in the United Kingdom, reporters pinned the murders on Boots’s cessation of antidepressants and the ostensible resurgence of her postpartum depression (e.g. *CBC News* 2012, *BBC News* 2012). When this came up in conversation with a local survivor activist, she wearily shook her head and, with no prompting from me, promised to write to news outlets explaining that it was Boots’ antidepressant usage that had induced her impulsive violence, not her depression. Most compellingly, shortly after the December 14th 2012 massacre at Sandy Hook Elementary School, I received a message on a local anti-psychiatry activist’s email list that read, in part, “I strongly suspect Adam Lanza was on at least one drug before or during his mass killing rampage.” While Lanza was known to have been on a prescription drug to treat a neurodevelopmental disorder, it is not currently known—and was, therefore, not known at the time this email was sent—whether that drug was a psychotropic or an SSRI. This activist’s immediate suspicions about Lanza’s blood chemistry (and, thus, level of volitional responsibility) may seem disturbingly premature, yet they are understandable in light of recent disclosures.

In summary, for many in the psychiatric survivor community, the notion that drugs compromise users’ volitional capacities has an axiomatic status. Indeed, according to psychiatrist Bradley Lewis (2006a: 130), these allegations have “become so widely credible” that even the tide of professional opinion is beginning to turn. And, as asserted in an independently published guidebook on psychiatric drug discontinuation that had a wide circulation among local survivors,

> Once you are on the drug, your personality and critical thinking abilities may be very changed. It might be difficult to properly evaluate the drug’s usefulness. You may need to get off the drug, but not realize it because of how the drug is affecting your thinking (Hall 2007: 20).

By foregrounding the above regulatory warnings, news stories, and interactions, my purpose is to sketch out the background to a specific ideological litmus test that aspiring members of some anti-psychiatry communities seem obliged to pass, at least if they want to avoid allegations of sanism (prejudice against “the minority of us perceived as irrational,” “unreasonable,” “volatile” “crazy,” “psycho,” or “mad,” which is said to undermine positive representations of such individuals; Oaks 2010: 5, Ryan, section 2.1). The test is: you must accept that the iatrogenic effects of psychiatric drugs may include compromised judgement and involuntary violence, and
you must trust the knowledge claims of those who have had firsthand experience on such drugs, because this firsthand experience is uniquely endured by individuals officially deemed mad, irrational, unreasonable, etc. As Olivia put it during a conversation more than two years after the events described in this chapter, to tell an SSRI survivor that SSRIs cannot incite destructive urges in their users “is like telling women catcalls aren’t catcalls—you’re telling us we don’t know our own lives.”

While Unhinged had no formalized policies, attendees were regularly reminded that the group was a “safe space” for members who had had firsthand experience within psychiatric systems: that is, a space that eschews sanism and respects the truth claims of people who have been deemed officially insane (e.g. that drugs, rather than “mental illnesses,” displace authentic personalities, chapters 4-6). In such “safe spaces,” it is considered a serious transgression of group norms for someone who has never known neurochemical iatrogenesis firsthand to deny the iatrogenic claims of someone who has. The furious reaction that Ivy received in late February when she, for the second time in three months, wholly rejected the notion that SSRIs could compel a user to commit horrific, uncharacteristic deeds, must therefore be understood in light of four expectations that the group took for granted:

1. Ivy had no firsthand experience on psychiatric drugs of any sort. Therefore, she was disentitled to advance opinions about psychiatric drugs that contradicted the opinions of members who had been on psychiatric drugs, so as to maintain the “safety” of the space for such members.

2. Ryan had firsthand experience on an SSRI, Zoloft. While he maintained a policy of silence around his own psychiatric experience (see chapter 5), making it impossible to know whether or in what way he had endured “SSRI psychosis,” he was entitled to advance opinions about such drugs, because the “safe space” was designed specifically for members in his position.

3. Therefore, Ryan’s opinions about the volitional influences of SSRIs were protected within the “safe space,” even if his opinions were serviceable to other forms of social injustice (e.g. providing an alibi for school shooters, who are virtually all male).121

---

121 It is important to note that school shooters are a racially diverse population: the November 1991 massacre at the University of Iowa was committed by a Chinese man, the April 2012 massacre at Oikos University was committed by a South Korean man, the March 2005 massacre at Red Lake Senior High was committed by an Ojibwe boy, the deadliest singly perpetrated mass shooting in U.S. history was committed in April 2007 by a South Korean man (the “Virginia Tech” massacre), and gun crimes affect many black and Hispanic youth in urban American schools. However, as Kalish and Kimmel (2010: 452) point out, it is generally “only when white boys began to open fire in their schools [that] psychologists and journalists rush to diagnosis of mental illness” in ways that prompt soul-searching about the determinants of violence in the national media.
4. Ivy’s opinions about the volitional influences of SSRIs were not protected within the “safe space”—and were deemed a form of “sanism”—even if her opinions implicitly challenged other forms of social injustice (e.g. refusing to exculpate perpetrators of a highly gendered crime).

On the one hand, it is vital for SSRI survivors’ allies to take seriously the accumulating, disturbing evidence of a link between antidepressant usage and impulsive violence, particularly in a society that treats “mentally ill” bodies as reservoirs of unpredictable danger. Psychiatric survivor activists face the triple dilemma of having to explain a medicated person’s violence, disclaim his legal responsibility, and not blame an “underlying” mental illness (as the mainstream media typically do; see chapter 4). By pinning crimes on medications rather than “mental illnesses,” activists can provide seemingly adequate explanations for seemingly senseless acts of violence without having to endorse DSM nosologies. The argument that psychiatric drugs alter users’ authentic personalities thus offers an elegant solution to the above dilemma, despite its epistemological problems (see section 2.2). We must also remember that large companies have spent billions of dollars promoting SSRIs over the last thirty years: if certain pharmaceutical compounds are linked to violent compulsions, it is not their chemical structures that are at fault, but the human beings who decided to market them as emotional anaesthetics. And so, there is no doubt that “safe spaces” in which psychiatric survivors can openly voice their frustrations on these topics perform a rare and valuable function for people like Ashley, Olivia, Ryan, MacDaniel, Richter, Pascal, and their peers. Their stories of psychiatrization depart significantly from mainline depictions of biopsychiatry and “mental illness” as forces that (respectively) heal and derange, and it is only natural for people who dissent from this view to want to be able to dissent in peace.

However, a space that is structured to ensure “safety” for one type of person may be definitionally and disproportionally “unsafe” for other types of people—due to the principles that structure the space, not the intentions that govern it. To put it another way, might Ivy’s disqualification from the “psychiatric survivor” identity on the basis that she had never seen a psychiatrist or taken drugs signal a problem with the definitional parameters of that identity, rather than with Ivy herself? Moreover, might Ivy’s repeated rejection of the notion that SSRIs have irresistible coercive powers—an opinion that is anathema to many SSRI survivors—be interpretable as something other than “sanism”?

In The Protest Psychosis: How Schizophrenia Became a Black Disease, Jonathan Metzl (2010) describes how the DSM-II’s redefinition of schizophrenia—which introduced “aggression” and “hostility” into the disorder’s diagnostic features—led to a marked increase in
schizophrenia diagnoses among African Americans involved in Civil Rights activism. Metzl argues that the dramatic rise in hospitalization rates of African Americans during this period flags an important way in which racism can become institutionalized in disciplinary norms, such as diagnostic codes and medical curricula, sensitizing the professional gaze to some manifestations of violence while diverting it from others. It is in the context of Metzl’s insight about the semantic institutionalization of racism that we must unpack Ivy’s dilemma within Unhinged, where she was not considered a bona fide “psychiatric survivor” and was thus disentitled to speak as freely as the others. As Whitley et al. have documented, “non-European immigrants” to Canada are known for their disproportional reluctance to access mental health services, a finding to which the authors attribute multiple determinants: lack of confidence in English, a “perceived overwillingness of doctors to rely on pharmaceutical medications as interventions,” encounters of dismissive attitudes from healthcare workers that deter them from accessing healthcare in general, and a preference for alternative registers and idioms of distress through which to interpret and respond to symptoms (“most notably God and to a lesser extent, traditional folk medicine,” 2006: 205). In 2009, a Mental Health Commission of Canada (MHCC) investigation similarly found that “ethno-racial” populations are significantly less likely to access mental health services, despite higher rates of mental ill-health in “refugee groups, some recent immigrant groups and in existing racialized and ethno-cultural groups” (Mental Health Commission of Canada Service System Advisory Committee 2009: 7). For the MHCC, there are five main determinants of this phenomenon: “ethno-racial” people’s unawareness of the availability of mental health services, aversion to racial discrimination at the hands of healthcare workers, linguistic barriers, tendency (due to economic insecurity) to have less flexible work schedules in which to fit medical appointments, and fear of stigma (2009: 15-17).

What is notable about all of these explanations is the overarching framework in which they are advanced, in which “non-European immigrants” and “ethno-racial” individuals are seen as lacking either the knowledge or the ability to do what is best for themselves: to seek timely professional help for “the management of stress” (MHCC Service System Advisory Committee 2009: 17), which is seen as the default option, and to abandon retrograde superstitions about “God” or “traditional folk medicine” in favour of modern science. Such individuals are said to face “barriers to care” (MHCC Service System Advisory Committee 2009: 15), located either in society or in themselves (e.g. inaccurate worldviews or misperceptions about doctors), and it is assumed that the removal of these “barriers” will lead to their enhanced use of conventional mental health services. However, Ivy’s non-usage of mental health services arose less from
barriers than, in a sense, from a distaste for barriers: according to her, the reason her family “didn’t believe in” psychiatry was that they saw psychiatric diagnoses as “excuses”—that is, impediments to a stance of personal responsibility. As she put it,

They just think the whole thing is kind of stupid. Do you know what I mean? ((pause)) Like, it’s like, if you tell them, ‘I hate my life and I want to die,’ they just think it’s really stupid. They think you’re making excuses, like you don’t want to work. Do you know what I mean? Like, I don’t know, they just think it’s [the idea of seeking psychiatric treatment is] stupid. Like, they’ll go, like ‘Don’t think so hard about it—just do the work!’ I don’t know.

The enjoinder to “just do the work” is, of course, serviceable to neoliberal systems that blame individuals for their own problems while denying them the resources to solve those problems (chapter 6). While Ivy never revealed the essential nature of her “madness” to her parents (cleansing green curtains of energy, perceptions of contaminants legitimating a continual need to wash with cold water), she did eventually announce to them, after quitting her first year of university, that her GP had diagnosed her with Obsessive Compulsive Disorder. They interpreted this confession as a deferral of responsibility (“they just thought I was making excuses”) and lectured her on the need to “work hard, like hard, hard, hard” to overcome what they called a “fake disability.” As we saw in chapter 5, Ivy’s “mental illness”—preoccupations and routines pertaining to the management of filth, and a mastery of those routines that gave her a sense of control in an otherwise intolerable environment—in fact entailed quite a lot of “hard work.” Her parents’ failure to grasp the gravity of her distress, and their eschewal of both psychiatry and the concept of psychiatric illness had three consequences for her positionality in Unhinged. First, she could not have seen a psychiatrist and received official treatments without losing her parents’ respect. Second, she thus avoided any possible help and/or harm that might have resulted from psychiatric treatments. Third, she consequently had no firsthand reason to suspect that treatments might result in harms prior to her entrée into the mainline psychiatric survivor community.

Thus, Ivy’s marginal status under Unhinged’s “safe space” policy must be understood in a broader light: as a racialized person, she belonged to a demographic that is disproportionately less subject to formal psychiatric intervention in Canada, and whose members are, by extension, disproportionateness less likely to have personally experienced formal psychiatric intervention—and less likely to be or become eligible for membership in the standard definition of “psychiatric

122 The question of “why” Ivy’s family disbelieved in psychiatry must also be seen as, in some ways, wrongly put. Our society’s conception of biomedical healthcare as a default is fortified by the problematic premise that Western disciplinary traditions have “no ‘culture’ in the anthropological sense of the term… Everything is thus ‘natural’—in other words, the way things are done is the ‘best’ way because it is ‘healthier’ or ‘simpler’ or more ‘rational’ (de Lima 1992: 202). Would the MHCC have issued a special report on the distinctive traits and beliefs of non-“ethnoroacial” individuals, and how those traits and beliefs represent “barriers” to health?
survivorship” (Reaume 2002). At the same time, as we will see, even if racialized people are less likely to be deemed officially insane, they are (arguably) more likely to be * unofficially treated as insane*. In this context, a “safe space” that structures participants’ entitlement or disentitlement to express opinions about psychiatric interventions to which they have been subject will tend to safeguard the input of white speakers more than racialized ones. At the same time, although Ivy claimed not to share her parents’ attitude toward disability, her own valorizations of “work” could and did put her at odds with the other Unhinged members, especially when conjoined with her disinterest in politics, feminism, and antipoverty activism, and her vast wealth.

Here, we must return to deconstructing the madness/sanity dichotomy. Even if we accept the notion that psychoactive drugs can induce “altered” states that lead to uncharacteristic acts or thoughts, it remains unclear why and how these alterations induce users to make decisions to which they, in their “unaltered” states, would presumably be averse. Are individuals who have “gone mad”—whether under chemical or other influences—truly unmoored from the common values of their society, community, and culture? Do Western juridical debates about responsibility adequately capture what is going on when a person succumbs to uncontrollable urges and impulses? To address this problem, we must explore the specific SSRI-related tragedy over which Ivy and Ryan would eventually wage their final fight.

2.3 Going Mad: Alteration or Amplification?

When Helen and I walked into the May Robinson Auditorium on a sunny July afternoon during Mad Pride Week 2009, a man was already standing at the front of the hall delivering an animated lecture with the aid of props and PowerPoint slides. We hadn’t yet checked the program and didn’t know who was talking or about what. “I’m getting seats,” Helen whispered. I nodded absently while browsing the pamphlets that were available at a nearby reception table. As I skimmed a brochure for the A-Way Express Courier Service (a citywide courier that is operated and staffed by psychiatric survivors), I distinctly heard the speaker say the words, “When I killed my son…” I turned around and tried to focus on what was being said, which was not easy in this particular auditorium, as its high, vaulted ceiling induced a significant amount of echoing. The speaker, a middle-aged white man who was slowly pacing back and forth in front of a large projection screen, seemed to be talking about the mental health benefits of exercise. Certain that I had misheard the beginning of that sentence, I joined Helen at the far side of the room, sat down, and leafed through the souvenir program I had just picked up. I quickly located a written description of the current lecture: a presentation by a man named David Carmichael, who was
going to help the audience “understand, based on his own experience recovering from major depression, how important it is to take responsibility for our own recovery and rehabilitation by asking our doctors and mental health workers questions, questions and more questions, and by becoming regularly physically active” (Mad Pride Week Organizing Committee 2009: 4). The blurb stated that the speaker held a Master’s degree in physical education, was the former Director of National Projects at the non-profit organization ParticipACTION, and that, after suffering from major depression in 2003 and 2004, he had learned “that doctor do not always know what’s best” (Mad Pride Week Organizing Committee 2009: 4).

Carmichael was a gifted lecturer and covered a wide range of topics within the space of an hour. He discussed how and why receiving a psychiatric diagnosis could alienate a person from their friends and family, how and why pharmaceutical company representatives marketed their products to doctors, the difficulties faced by corporate whistleblowers, the relationship between certain politicians and drug companies, and the impact of a sedentary lifestyle on a person’s lifetime physical and mental health. As the hour came to a close, Carmichael returned to the topic with which he had begun, which I could now hear with unmistakable clarity: the death of his son at his hands in the weeks following his abortive attempt to wean himself off of Paxil (see chapter 6), and his subsequent trial for first-degree murder. He explained that he was currently on conditional discharge and was still officially a ward of the state, and he acknowledged that “I’m very fortunate… if I were in South Carolina, I would be on death row.”

In a booklet that was distributed at the end of the lecture, Carmichael states that while awaiting trial at the Brockville Mental Health Centre a forensic psychiatrist told him

that Paxil, a popular antidepressant known as a selective serotonin reuptake inhibitor (SSRI), likely triggered the psychotic episode that caused me to kill my 11-year-old son Ian on July 31, 2004, not my major depression. He told me that the Food and Drug Administration (FDA) and Health Canada had recently published warnings about SSRIs and suicide. To support his view, Jim, a psychiatric nurse, brought me a photocopy of a few pages from the 1996 edition of the Compendium of Pharmaceuticals and Specialties (CPS)... Sure enough, delusions and psychosis were listed as rare side effects of Paxil, which means that GlaxoSmithKline, the manufacturer of Paxil, acknowledges that 1 in 1,000 people may become delusional and experience a psychotic episode while on the drug. … I will never know if I was that 1 in 1,000 and if Paxil did indeed make me severely delusional. … [However] If illegal psychotropic drugs such as marijuana, LSD, cocaine, and methamphetamine can trigger an acute psychotic episode that causes people to commit suicide and/or homicide, it seems reasonable to assume that Paxil, a prescribed psychotropic drug, can also trigger a violent psychotic episode (Carmichael N.d.: 3).

In September 2005, Carmichael was judged to be “not criminally responsible on account of a mental disorder” (not on account of Paxil influence, but on account of major depression) and remanded into state custody. In the summer of 2006, after hearing on the news that Andrea Yates had been found not guilty of murder by reason of insanity, and discussing his desire to speak out
publicly about the risks of psychotropic drugs with his wife and daughter, Carmichael decided to contact the media. In April 2007, CTV’s *W-FIVE* featured Carmichael’s story on air and raised questions about what role Paxil—and its manufacturer, the pharmaceutical multinational GlaxoSmithKline—might have played in his homicide in light of the antidepressant’s known link to adolescent suicides (CTV 2007). “If I am not criminally responsible for Ian’s death,” Carmichael forcefully contended as Helen shifted uncomfortably beside me, “then maybe someone else is.”

Helen was quiet when we exited the auditorium, and she walked slowly, seemingly lost in thought. I did not know her very well at that time, although I did know that she had young children, one of whom was the same age that Ian Carmichael had been at the time of his death. We finally made our way outside, and, as she stopped to check her text messages, she said, without looking up, “I don’t see how you can say a drug made you kill your child. Doesn’t make sense to me.”

* * *

Michael Lambek (2010: 720) has deftly problematized the Western assumption “that a unified state of mind, exemplified by pure reason as opposed to passion, is the necessary basis for sound ethical judgment and action” by calling attention to the countless internal discontinuities and heterogeneous personas that are at play in any given life at any given time: a person is not necessarily, for example, the “same” person in the presence of her family as she is when performing ethnographic fieldwork, posting anonymously on an online discussion forum, being interviewed for a job, or experiencing a caffeine high, an excruciating headache, significant sleep deprivation, ravenous hunger, or intense worry. The prevailing notion that rational individuals possess a consistent, unadulterated outlook throughout their lives and that any past, present, and

123 In June 2001, Yates drowned her five children in a bathtub, citing a desire “to save them from Satan” and a belief “that by drowning her children she was saving them from hell” (Denno 2003: 3, footnote 20). In 2002, she was convicted of capital murder and sentenced to life in prison. In 2005, this conviction was reversed on appeal, due to a forensic psychiatrist’s admission that he had given materially false testimony during the trial: he had told the jury that, shortly before Yates’s crime, an episode of *Law & Order* had aired in which a woman successfully leveraged the insanity defense to win an acquittal after drowning her children; in fact, no such episode existed at the time (Liptak 2005; see also Denno 2003: 23-25). In July 2006, a new jury found Yates not guilty by reason of insanity, as she had been diagnosed with postpartum psychosis at the time of the killings. She was then committed to the North Texas State Hospital. The part of this story that interested Carmichael was the fact that, a month before the killings, Yates had been on a high dosage of the SNRI antidepressant Effexor (venlafaxine) and, in the days leading up to the killings, her psychiatrist had decided to reduce her dosage dramatically rather than incrementally—he “reduce[d] her Effexor prescription by 150 milligrams in one day, despite Russell’s [her husband’s] research indicating that the anti-depressant should not be reduced by more than 75 milligrams over 3-4 days” (Denno 2003: 70).

124 Throughout this discussion, the word “ethical” should be taken to mean “subject to ethical evaluation” rather than “morally virtuous” (Lambek 2008, 2011).
future action can therefore be deemed either “in character” or “out of character” is belied even by
the standards of Western juridical practice (e.g. the often nebulous distinction between first and
second degree murder, Lambek 2011). In short, a robust model of personhood must acknowledge
“the unfathomability of the sources of our judgment and action” and confront the fact that people
do inexplicable things for ambiguous reasons all the time (Lambek 2010: 722).

Given that rationality tends to be conflated with an “unaltered” consciousness in our
society, what is an “altered” state? What does it mean to be, or not to be, in one’s “right mind”? Despite a certain degree of plasticity in Western legal conventions, questions of criminal
responsibility remain hinged on determinations of whether the perpetrator of an act had, at the
time of its commission, the mental capacity to appreciation its consequences. As stated in
Section 16 of the Criminal Code of Canada,

16. (1) No person is criminally responsible for an act committed or an omission made while suffering from
a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or
omission or of knowing that it was wrong (Department of Justice, Canada 2012 [1985]).

This is the defence that was successfully leveraged by Carmichael’s defence attorneys during his
legal proceedings. However, this definition presents us with a problem. In his speeches and
writings, Carmichael has repeatedly stated that he understood what he was doing when he killed
Ian, that his thoughts were calm and lucid during the murder, and that he was fully aware that he
would be charged, convicted, and imprisoned. During his Mad Pride lecture, he explained that he
deemed the inevitable costs of his act acceptable because they seemed, at the time, to be
outweighed by a particular benefit: during his psychotic episode, he became unshakably
convinced that his son was “brain damaged” and therefore “in a living hell,” and he was
determined to end his son’s suffering. As stated in the booklet that accompanied his presentation,
after strangling Ian, Carmichael shaved, showered, cleaned up, called 911, and then

I calmly told the dispatcher that I was reporting a homicide, and that I had killed my son. She kept me on
the line. I told her that I was not suicidal. Towards the end of the call, I moved away from the phone to put
a plastic cup under the door so the door would be open for the police. I thought my family would
understand why I killed Ian. The most difficult thing for me to hear was when a former boss visited me at
the London Middlesex Detention Centre on August 3 and told me that my wife Elizabeth would never
forgive me. In my psychotic state, I thought that Elizabeth and my daughter Gillian would be thanking me
for saving Ian from a life of hell... I was confused and devastated (Carmichael N.d.: 4).

It is clear from all accounts that Carmichael, in his “unaltered” state, fully recognizes the
wrongful nature of his act: he is no longer on Paxil, and his current vocation as a public speaker
who is heavily involved in psychiatric survivor/consumer/Mad activism is an outgrowth of what
he has called an unachievable, lifelong process of atonement. What is significant about his story
is that his description of what it feels like to be in an “altered” state—a state of psychosis—is
very much at odds with the mass media’s characterization of psychosis. According to Carmichael, the conviction that he had to kill his son crystallized from the following train of logic: Ian was suffering horrendously from a brain injury and, therefore, to end his life would be to end his pain. Carmichael’s crime is discussed and debated within a psychiatric framework rather than a bioethical one because his syllogism contained a false premise: Ian did not suffer from brain damage. Were this not the case, Carmichael might have enjoyed some of the public sympathy that, for example, Robert Latimer did when he asphyxiated his disabled daughter in 1993 and ignited nationwide debates about euthanasia and compassionate sentencing. The fact that, while psychotic, Carmichael felt obligated to perform what he saw as an ethical duty reveals that it is possible to both understand that an act is wrong, or will be seen as wrong, and to nonetheless view it as the right thing to do. Mass media representations of psychosis as a state defined by the absence of reason (e.g. a rational mind displaced by disease) thus serve to conceal the centrality of ethical judgement even to people whose choices are made under heavily compromised circumstances. As Louis Menand has pointed out,

‘Do the right thing’ and ‘Tell the truth’ are only suggestions about criteria, not answers to actual dilemmas. The actual dilemma is what, in the particular case staring you in the face, the right thing to do or the honest thing to say really is. … When we are happy with a decision, it doesn’t feel arbitrary; it feels like the decision we had to reach. And this is because its inevitability is a function of its ‘fit’ with the whole inchoate set of assumptions of our self-understanding and of the social world we inhabit, the assumptions that give the moral weight—much greater moral weight than logic or taste could ever give—to every judgment we make. This is why, so often, we know we’re right before we know why we’re right (Menand 2001: 351, 353, italics in original; quoted in Lambek 2008: 137).

To illustrate the complexity of this observation, a brief auto-ethnographic interlude may be in order. On a warm spring evening in 2010, I suffered an anaphylactic attack and was taken to York Central Hospital, where I received an injection of adrenaline and a prescription for a corticosteroid compound called prednisone. As he wrote out the prescription, the doctor stated that the purpose of the prednisone was to counteract a secondary allergic reaction and cautioned me that its side-effects included anxiety and nervousness. I was to take an oral dosage of 30

125 In October 1993, Canadian farmer Robert Latimer killed his 12 year-old daughter Tracy by placing her in his truck and siphoning exhaust fumes into the enclosed cab. Tracy had cerebral palsy, could not walk or talk, suffered from seizures, and had been scheduled for hip surgery the next month. Latimer was charged with first-degree murder and convicted of second-degree murder. The Supreme Court of Canada later ordered a new trial amid allegations of jury tampering in the original trial; in 1997, Latimer was again found guilty of second-degree murder. In 1999, an Ipsos poll found that 73% of Canadians believed that Latimer had killed Tracy “out of compassion and should receive a more lenient sentence,” and that 41% of Canadians believed that “mercy killing” should be legal (Ipsos 1999: para. 2-3). Disability rights advocates countered that showing leniency to Latimer would devalue the lives of disabled people, particularly those who are unable to speak for themselves. In August 2010, the National Parole Board was instructed by a federal court judge to “make the least restrictive determination consistent with the protection of society” after finding Latimer at “very low risk” of reoffending (CBC News 2010a: para. 9, 5). In November 2010, Latimer was granted full parole.
milligrams each day for a week. I nodded absent-mindedly, shivering from the adrenaline, annoyed at the interruption to my workweek. After being discharged a few hours later, I purchased the drugs at a local pharmacy and returned home. Over the next three days, I dutifully took the prescribed dosages and became, during this interval, suicidally depressed.\footnote{Case reports in the clinical literature have consistently established a link between the use of corticosteroids and the onset of disturbances such as anxiety, delirium, hallucinations, mania, and fearfulness (see French et al. 2003 and Perantie and Brown 2002 for literature reviews). The effect is sometimes called “steroid psychosis” (Sirois 2003) or “corticosteroid psychosis” (Muzyk et al. 2010).} The depressive feelings were similar in content but dissimilar in form to the depression of my teenaged years. Urgent, inescapable conclusions frothed at the forefront of my mind, seemingly impossible to evict, and yet the conclusions themselves—the utter conviction that I was too introverted and socially illiterate to achieve anything in life, that the uphill battle was too exhausting to continue, that I should quit while I was ahead—were not unfamiliar to me, and indeed felt more reasonable than they ever had before. It was, for lack of a better analogy, not the melody of the music that became unbearable, but its volume, key, and instrumentation. Approximately a day after I took my last prednisone tablets, the suicidal urges and pessimistic convictions evaporated. The change was stark and perceptible. To use Menand’s phrasing, the assumptions that had imbued my suicidality with moral weight no longer felt irrecusably right; I no longer “knew” what I had “known” just twenty-four hours earlier.

Prednisone is not classified as a psychotropic drug: its medical indications are immunological rather than psychiatric, and the above experience has not necessarily given me any insight into what it feels like to be on antidepressants or antipsychotics. Nonetheless, this episode—which serendipitously took place in the middle of my fieldwork year—did add a new layer to my understanding of my informants’ countless narratives about feeling as though their authentic selves had been displaced, usurped, pervaded and possessed by psychopharmaceutical compounds. Up until that point, I had maintained a certain degree of skepticism toward the notion that a chemical could so fundamentally alter a person’s disposition as to compel them to commit deeds they “normally” would not. Would a person with no compelling reasons to end his own life really commit suicide simply because of a medication? Becoming uncharacteristically homicidal due to medicinal influences seemed even more beyond the pale. However, after the above episode, I began to realize that my skepticisms were originating from a flawed supposition that underpins much Western philosophical thought: that there is a binary distinction between reason and passion, and that an individual can resist any passion so long as she anchors her
decisions in rational, logical trains of thought. In a sense, it would be erroneous to call what I experienced on prednisone a suicidal “urge,” as though a felt compulsion can be somehow neatly distinguished from higher order mental functions. The premises upon which we base the conclusions we draw in life—whether those conclusions are discredited as mere “urges” or elevated as “inferences,” “hypotheses,” and “theorizations”—are rarely ours to choose. Even if it can be said that my prednisone-induced suicidality was irrational, where did I get the idea that introversion is a problematic trait?

When Helen cast doubt on David Carmichael’s credibility after his Mad Pride lecture, and when, five months later, Ivy refused to tolerate Ryan’s continual attempts to defend the Columbine gunmen, I was strongly sympathetic to their position. I remain sympathetic to the stance that people must take responsibility for their actions: the fact that Eric Harris had Luvox in his bloodstream when he decided to murder his classmates does not mitigate the act’s wrongness. Nonetheless, it is of paramount importance to link this stance to an underlying dogma that animates many such denunciations of violent offenders: the notion that other people’s attitudes are basically none of our business until and unless they act on them—that the inability to restrain oneself (“losing control”) is the point at which one crosses over into madness—after which one’s acts enter the realm of moral valuation and become grist for forensic psychiatric scrutiny. This doctrine neatly elides the role of society at large in imparting people with mores and priorities that give rise to certain patterns of violent madness: where did Carmichael get the rather eugenic idea that living with brain damage necessarily means being in a living hell, for example? If the Columbine gunmen felt bullied and emasculated, what are the cultural narratives that made a hyper-masculine show of force seem like a suitable form of retaliation (see Kalish and Kimmel 2010)? As Fox and Ore point out about a decision to hold an adult trial for a fifteen year-old Californian boy charged with murdering a gay classmate,

Some may applaud this as an appropriate institutional response that creates greater safety for other queer students. However, this response suggests that McInerney came up with the homophobia and genderism on his own, thereby freeing society from an analysis of the larger problem—which is precisely where he got those ideas. McInerney becomes a scapegoat, and the state and society are freed from dealing with the issue. This move to place absolute guilt on the individual is the same logic used in the sexual torture and humiliation of the prisoners in Abu Ghraib, sexual torture and humiliation that occurred at the intersections

127 In a journal entry dated November 12th 1998, Eric Harris wrote, “Everyone is always making fun of me because of how I look, how fucking weak I am and shit, well I will get you all back: ultimate fucking revenge here. you people could have shown more respect, treated me better, asked for my knowledge or guidance [sic] more, treated me more like [a] senior, and maybe I wouldn’t have been as ready to tear your fucking heads off. …Thats [sic] where a lot of my hate grows from, the fact that I have practically no selfesteem [sic], especially concerning girls and looks and such. therefore people make fun of me... constantly” (Harris 1998, second ellipsis in original).
of racism, homophobia, and imperialism and fed by discourses of national safety and security (2010: 645-646).

My point here is emphatically not that the attitudes that give rise to predictable patterns of violence need to be screened for and pathologized, but that they need to be de-pathologized: de-individuated and acknowledged as genres of reasoning that are far from anomalous, in which we are all complicit, and for which we all merit critique. When a violent person is dismissed as “insane,” a “psychopath” or “not criminally responsible on account of a mental disorder,” his actions are displaced from a spectrum of chauvinisms that are varyingly condoned, cultivated, and even championed throughout his society, the recognition of which might help to erode the line between madness and sanity. As we saw in chapter 6, it is sometimes argued that authorities have an ethical duty to enforce treatment compliance in patients with “poor insight” because unchecked “mental illnesses” can cause sufferers to harm themselves or others. This assertion conveniently elides the fact that non-psychiatrized—“sane”—people inflict brutal harm on themselves and others all the time on the basis of attitudes and sensibilities that do not get them classified as incompetent and forcibly detained. In mainstream society, it is considered perfectly “sane” and “normal” to, for example, invest in extractive industries that devastate natural habitats, consume agribusiness products that ruin local economies, endorse unsustainable energy sources, support imperial military ventures, advocate the dismantlement of vital social services, purchase garments manufactured in sweatshops, and to make casual, offhand jokes about people who fail to live up to arbitrary standards of femininity, masculinity, or able-bodiedness that, bit by bit, contribute to the idea that they are dispensable people. In such a context, as we will now see, the Mad Pride ethos that every person should be “free to be me,” and that curtailments of such freedoms are “sanist,” can sometimes become a fig leaf for chauvinisms that target other forms of marginality and intensify other forms of pain. After all, the ambitions and aversions that comprise any particular “me” always have a broader socio-cultural provenance, aspects of which may infringe on others’ freedom to be whom they are.

128 As Derek Summerfield (1999: 1451) has pointed out, humanitarian agencies and the media have “promoted the idea of war as a sort of mental health emergency” in which soldiers and refugees are likely to require psychiatric help. Yet it is rare for the news media to question the mental soundness of those who orchestrate these wars: presidents, executive officers, senior advisors, high-rank military personnel.
3. **On the Accumulation of Tiny Indignities**

3.1 **The Eye of the Storm: “Hey Princess, This Isn’t Dinner Theatre.”**

Three additional Unhinged meetings took place in the month after that fateful, midwinter argument over Ivy’s violation of the “safe space,” two of which Ivy attended without serious incident. Naively, I had assumed that the group would congeal again and that all would be forgotten. It was not unprecedented for members to angrily walk out on meetings due to subtle slights that others had failed to notice, and such members had always returned to the fold (e.g. Nathan once felt that everyone was deliberately talking over him and thus devaluing his input, and he stormed off in a rage, only to return apologetically within the hour). My inattentiveness to the political significance of these outbursts was in part shaped by the fact that I did not, at that time, grasp their relevance to my research agenda, and, in Ivy’s case, by the fact that she had a tendency to speak her mind in insensitive ways that may have discredited her actions in my mind’s eye. Once, when the two of us were at a restaurant, she spent a solid minute berating the waitress for mixing up her order, undeterred by my nervous attempts to de-escalate the situation. On countless other occasions, she made mortifying remarks to others, seemingly in total innocence, at which I could not help but cringe: telling Melinda that she was enviably pear-shaped but needed to “lose [her] gut,” repeatedly asking Alyssa why she did not have a boyfriend, giving Fleming unsolicited advice on how to cure his acne because she was clearly addicted, and urging me to have my teeth orthodontically straightened. In all such instances, the suggestions and observations were put forth in apparently good faith. It never seemed to me that she was attempting to insult anyone, only that she thought it right to voice her opinion. Others in the group typically responded with good humour or gentle condescension (“Okay, great, thanks for the tip”) and Ivy seemed placated by these acknowledgements (“Good—and trust me, you’re gonna thank me later”).

In hindsight, Ivy’s determination to advise others on aspects of their lives that she found wanting was not so far removed from the logic that animated Cassidy’s relentless attempts to rehabilitate the eating habits of everyone she knew, and MacDaniel’s periodic lectures about the need for psychiatric survivors to equip themselves with “a job, a place to live, education,” and “to learn to go it alone” (chapter 6). All three speakers seemed genuinely interested in sharing remedial insights that they felt others lacked, and each set of recommendations was advanced within a framework of personal choice that did not always or easily accommodate structural
obstacles. What primarily differentiated Ivy’s comments from Cassidy’s and MacDaniel’s was the fact that they were not explicitly (or obviously) linked to questions of mental health or psychiatric survivorship, and, indeed, tended to surface out of nowhere during conversations about unrelated topics. Although, as in the below examples, I eventually came to discern a deeper significance to her non sequiturs, Ivy’s tendency to embark on seemingly irrelevant tangents sometimes made her difficult to interview, and my field notes contain at least three or four entries that express mild frustration with her contributions to group discussions. In March 2010, for instance, shortly after one of the last Unhinged meetings that she attended, I wrote the following entry in my field notebook:

My turn to bring snacks today. Chewy nut bars for everyone ($2.99 a box at Shoppers). DM is ecstatic at the “healthy food,” which I’d never thought of as especially healthy—that’s privilege talking. The whole conversation, and not for the first time, is: without affordable housing, we are never going to see improvements in psychiatric incarceration rates. There is a solid consensus around the table: having a place to call your own is lifesaving, the best possible predictor of health, mental or otherwise. Ryan: there’s no such thing as health without safety, no safety without privacy, no privacy without a room with a door that locks. With $20 and no home, all you can do is buy crack and McDonald’s, but with $20 and a home you can buy Clorox and Sunlight and fresh meat and vegetables (refrigerator food). Good point. Cf. misconceptions about personal responsibility vs. structuration. Ivy wants to know—every 30 seconds she wants to know!—if we want to go for dinner at the Japanese place down the street. “Do you guys wanna go to Omi?” over and over. She’s so into this idea, she can’t stop talking about it. Take it easy, you know? Ryan is pissed. He goes, “Hey, princess, this isn’t dinner theatre.” Probably an overreaction. She’s quiet again for most of the night.

In hindsight, although this did not occur to me at the time, it is possible to discern a connection between Ivy’s desire to reconvene at a sushi bar (called “Omi”) and the topic of the conversation at hand. Up until that point, much of the interaction had revolved around the subject of malnourishment. When I brought in granola bars at the meeting’s outset, one member expressed delight at the snack’s wholesomeness, a reaction that surprised me, as I was accustomed to having access to healthier options in my daily life. However, I mentally set this exchange aside as the meeting officially began and a new topic was introduced: the relationship between housing and mental health. To explicate this relationship, Ryan pointed out that spatial and material resources do not just shape but determine the spectrum of choices available to any person at any given time, and invoked the example of being able to diversify one’s diet only with the aid of a refrigerator in which to store perishable items. I was intrigued by this observation, and less so by Ivy’s inquiries about the restaurant, because Ryan’s contribution to the discussion felt articulate and apposite, whereas Ivy’s contributions felt like interruptions. Yet Ivy’s persistent repetition of a single query (“Do you guys wanna go to Omi?”) was arguably also “on topic.” In the vernacular, the phrase suggests that it is she who wants to “go to Omi,” and that she is trying to enlist support for relocating to a dining establishment. But another interpretation is possible: Ivy
had a long history of treating the other Unhinged members to meals, giving them rides, helping them move, and bringing them gifts, and, in this context, her query may have been less of a request and more of an offer, made in response to repeated indications of nutritional need.

It is also possible that this latter interpretation was not lost on Ryan, who routinely denounced the concept of “charity” as an obstacle to social justice and affront to the dignity of the working class. Unlike the others, Ryan never accepted rides from Ivy. Once, when he needed to transport some hefty boxes from a rented storage locker to his home, Olivia suggested that he solicit the assistance of either Ivy or another friend with a car; he rejected this option out of hand, electing instead to tackle them one at a time with a folding dolly cart. Ryan was also the most critical Unhinged member when it came to the question of Ivy’s classification within the psychiatric survivor/consumer/ex-patient/Mad community. On the handful of occasions when this question arose, he was quick to point out her ineligibility for any of the “c/s/x” identities (“Well, you’ve never been in the system, so that’s out”) but conceded that she might qualify as “Mad” and invited her to identify, as the majority of the group did, as “anti-psychiatry.” She never contested his authority in this matter, although, to his annoyance, she did periodically observe that “I’m not a survivor of psychiatry, but I’m a survivor of something.” When she once said this in his presence, he laughingly quoted a line from the NBC sitcom Friends—“My wallet’s too small for my fifties! And my diamond shoes are too tight!”—that, in the original teleplay, was intended to mock the privileged nature of a particular character’s problem. Hence, when, in the above interaction, Ryan situated Ivy even further apart from the others by sardonically styling her “princess” and accusing her of treating their life narratives as forms of consumable entertainment (“dinner theatre”), he was hewing to an established pattern of behaviour in which he not only trivialized her on a regular basis but continually implicated her in the socio-economic inequalities that he associated with his own suffering. Ivy’s subsequent silence meant that no further conflicts erupted between her and Ryan during that meeting.

In early April, shortly before the group disintegrated, I was privy to another illustration of the gap between Ivy’s communicative style and that of the others, as well as the Unhinged members’ (and my own) tendency to overlook her participation in the group. Over a meal of Vietnamese spring rolls and vermicelli noodles that Ivy had picked up for that day’s meeting, the

On that occasion, as in others, Ivy behaved as though she had simply not heard the remark. Perhaps because she never appeared to object, either verbally or through overt facial cues, and perhaps because of Ryan’s jocular demeanour, none of the others ever reproached him for making what they no doubt saw as harmless jokes. When I once asked her to clarify her assertion that she was “a survivor of something,” her response was, “You know, like a tough life. I don’t know. Just, like, a tough life.” I will return to the significance of these two observations later.
group began discussing the inadequacies of the public education system. The conversation had taken a Freirean turn, and participants were gamely sharing personal anecdotes that unmasked the double-standards that Canadian schoolchildren are obliged to navigate from an early age: Nathan pointed out that linear grading scales compelled teachers to conflate performance with behaviour (“If you don’t hand your shit in on time, you lose marks, so, what do you want? Originality and independence or obedience?”) and Yashar agreed that “grades destroy the desire to learn.” Olivia was of the opinion that the problematic aspects of formal education systems were more “curricular,” in that it was their subject matter that needed realignment rather than their methodologies per se (“I think large classes are fine, but if you’re going to teach World War II you better do it through Howard Zinn, who of course no one ever figures out he exists until it’s too late”). Alyssa added,

There’s something interesting in what you were saying, about it being systemic, uh, that it’s in the system that makes it so you’d have to be really quite privileged to study certain topics. I, it’s something I think about, too. Grade one, if in grade one, if we would have in school kids learning in grade one about—that they’re being targeted by corporations to sell jeans, to sell lip liner and iPods, and (multiple speakers cross-talking)—no, I’m dead serious—and here’s how to know when they’re making you feel like shit if you don’t dress right or if you look funny, I think. I mean, you think the teenage suicide rate would be what it is? I don’t think so. (multiple speakers cross-talking) With anorexia too, yeah, depression [Nathan, laughing: You want to teach No Logo in kindergarten?] Yes! I’m serious. Not No Logo. No, like, they should find a way to [Ivy: Eat your spring roll]—like we don’t teach trigonometry in kindergarten, but we teach counting and shapes. Start somewhere. I’m not joking, it’s a life skill. [Ivy: Here, it’s sauce.] It’s a public school system.

Ivy spent most of this meeting distributing vermicelli noodles, spring rolls, and dipping sauce between the seven other attendees, fussing over the food, and punctuating the discussion with interjections like, “Don’t hold your chopsticks like that,” and “Come on, just eat it.” While I at first found these comments distracting, I eventually noticed that, each time a speaker advanced an opinion that either resonated with the group or elicited a flurry of counterargument, Ivy made indications that he or she should eat more. It took me a long time to pick up on this pattern because of the conversation’s swift pace and multiple participants, and likely also because I was predisposed to mentally filtering out Ivy’s seemingly non-topical exclamations (as in the “Do you guys wanna go to Omi?” anecdote). The subtle logic that underwrote her contributions to this interaction became slightly more evident when Richter indicted the inadequacies of Ontario’s public health insurance and disability support programs:
demos [demonstrations] so you can meet other guys who are thinking for themselves. Health insurance, my ass! And—no, wait, wait ((multiple speakers cross-talking))—here’s—here’s something else if we can talk about it, the hypocrisy [Ivy: The last one, you want it?] When you’re a rich shrink, you can say, like, you can lie right in your patients’ faces. You know, ‘we know what schizophrenia is,’ and like, ‘the drugs have no long-term side effects,’ uh, ‘shock doesn’t wipe out people’s memories,’ oh, ‘you have to take these drugs forever,’ and nothing happens. But if you lie? When you’re a patient? It’s a crime. Literally, they take away your freedom [if] they find you lied about taking your pills. [Ryan: Oh my god, hear, hear!] ((multiple speakers cross-talking)) They’re against suicide, but it’s like—it’s like—[Ivy: Sauce.] they have no problem killing us slowly with no homes, no food, no books, no job training, nothing that makes a life a life.

In the above monologue, Richter avoided making the more common complaint that health insurance programs do not cover complementary and alternative medicine and, instead, put a twist on the medical consumerist axiom that people can make rational choices only when information is freely available. His contention was that, if OHIP and ODSP defrayed the costs of books, subscriptions to leftwing magazines, and transit fare to rallies held by likeminded dissenters, psychiatrized people would have more avenues for improving their mental health. This was the first and only time that I heard this particular critique of the public welfare system, although its overarching theme did map onto numerous other stories about the rehabilitative powers of information access that I had encountered over the course of the year (chapter 6). Ryan was especially appreciative of Richter’s novel insight (“Oh my god, hear, hear!”) and others reacted with similar exclamations of support. In comparison, Ivy’s (re)action seemed like a total non sequitur: she said the word “sauce” and gestured at the plastic cup of dipping sauce that sat next to Richter’s foil take-out carton. To parse this reaction, it should first be remembered that Ivy was not well-versed in the pageant of names and canonical texts to which the others had been alluding throughout this interaction (e.g. Olivia’s reference to historian Howard Zinn; Nathan’s reference to Naomi Klein’s anti-corporate bestseller No Logo; Richter’s reference to linguist-activist Noam Chomsky). It should also be remembered that, unlike most of the others, she had never experienced hospitalization or in-person maltreatment at the hands of psychiatrists, a distinction that Ryan would not let her forget. Thus, if Ivy had reacted to Richter’s remark about the unjust detention of non-compliant patients with the same overt enthusiasm as the others, she risked eliciting yet another one of Ryan’s sarcastic taunts. If she wished to express encouragement or moral support for people with whom she lacked a common vocabulary, or nip a potential argument in the bud, she was perhaps limited to doing so through indirect actions and gestures, lest she face accusations of insincerity.

---

I did, however, hear on multiple other occasions the related critique that “the state prefers buying people pills than good food” (Cassidy) and that “the government can’t afford to fund decent housing co-ops, but it can somehow afford to pay billions of dollars a year for mind-altering drugs” (Ana).
It is possible that I am reading too much into Ivy’s behaviour during this meeting. When it began to dawn on me that there may have been an underlying logic to her bizarre running commentary on the distribution of take-out food, I sorely regretted paying so little attention to her idiosyncrasies over the preceding eight months. Had I missed my opportunity to unravel the mystery of her commitment to Unhinged? What other clues had I overlooked? After the meeting adjourned, Ryan, Olivia and I walked to a nearby subway station. Since Ivy had declined to answer the question on several occasions, I decided to solicit their opinions on why she spent so much time with (and, indeed, resources on) this group despite the many dissimilarities that set her apart from the others.

Ryan replied without hesitation, with the curt defensiveness of someone who had long ago made up his mind: “Oh, that. Yeah, she’s trying to buy our friendship.”

* * *

Krista Van Vleet has noted that “anthropologists are often drawn into already ongoing histories of relationships among interlocutors that begin long before the anthropologists’ arrival and become part of scripts that may initially have little meaning for the anthropologist” (2002: 591). I never quite understood the reasons for Ryan’s hostility toward Ivy and always suspected that their fraught relationship had a specific back story to which I was not privy and which none of the others cared to share. Although I cannot claim to have unearthed the origins of the bad blood between them, a closer inspection of Ryan’s life history is instructive. In the above discussion about the rehabilitative virtues of housing, Ryan was alluding to a major turning point in his life: after being discharged from an addictions clinic, his mother’s brother hired him into a fulltime retail position in which one of his chief duties was to keep an eye out for shoplifters. When recounting this story, Ryan was emphatic that his uncle knew nothing of his own talent for petty theft (see chapter 5) and he seemed greatly amused by this irony. His attainment of a stable job had a significant impact on the course of his life, not least because the wages it furnished, however meagre, eventually allowed him to become financially independent of his mother and two brothers, whose moral surveillance became easier to bear from a distance. When he, for the first time, moved into a tiny, poorly maintained apartment of his own that nonetheless “had the whole works, a window, a fridge, my own fucking toilet,” he felt “like the king of the whole damn universe… every burden in your life lifts.”

It is because of sentiments like Ryan’s that psychiatric survivor activists have been steadfast supporters of affordable housing programs and have consistently sought to highlight a
link between housing and recovery from ostensibly lifelong mental illnesses (Capponi 1997, 2003; Chamberlain 2009; Monsebraaten 2010; see also MacDaniel’s story in chapter 6). In a way, it is unsurprising that a private living space can be such a powerful determinant of mental wellness, given that the inability to partition oneself from others’ moral gaze in a communal living space can lead a person to feel inescapably studied and judged—unable, that is, to “be free to be me.” Ryan himself once hypothesized that his addiction to theft was a natural outgrowth of his need to gain control over at least one area of his life (“It could be that it was, like, a subconscious thing, where you’ve got to have, like, one thing where you’re the one with power… cause, frankly, I was the best, I was unstoppable”) and he noticed clear and dramatic shifts in his outlook upon securing his own living space. The inexorable urges to steal that he had previously felt, which he stressed had not subsided after his release from the clinic, began to subside only after he moved away from his immediate family. However, the value of Ryan’s job transcended its provision of income alone. Because of his own prolific shoplifting career, he was familiar with the counterintuitive tactics and techniques that shoplifters employed (e.g. contrary to filmic depictions, they do not glance around furtively while pocketing merchandise, nor do they attempt to hide their faces from cameras) and he thus excelled in his new position. As Olivia dryly put it, “He thinks he’s Frank Abagnale.” Hence, in addition to financial stability, the job furnished an alternative outlet for the pride and pleasure that Ryan had once taken in being “unstoppable,” “the best.”

Of equal importance, it was in his new building that he met one of his best friends, MacDaniel, and, through him, became acquainted with the facts and ideas that would soon form the bedrock of his Mad identity. Once, while delivering a forceful slap to a startled MacDaniel’s backside, Ryan announced, “I love this guy! Every time he lends me a book, it has the same title: *Why Your Life Sucks So Fucking Much.*” On another occasion, Ryan stated that

> it’s basically, he [MacDaniel] was basically the Morpheus to my Neo. Like, cause that’s what it is, right? Once you can peel back the noise and, like all the stupid fucking distractions, and you can see the inner workings of the machine, um, how we’re being lied to, and, when we can’t eat, the richer get richer, and they don’t want us to eat, they want us to take a painkiller. And they tell us there’s no power, we’re all equal, and, you know, you deserve as little or as much as your parents had. You can’t go back. It’s the blue pill, red pill thing. Literally—it is literally true—you see the world with new eyes. … Sometimes I feel sorry for those guys on Bay Street. You know? It’s like, cause if you have so fucking much invested, in the system, in the machine, you can never really see what the rest of us can see. It’s not that you won’t—you literally can’t, cause you *are* the machine.

131 The reference is to a former cheque forger and confidence artist who, after his eventual arrest and incarceration at the age of 21, became a professional security consultant for the FBI. Abagnale’s story was the basis of Steven Spielberg’s 2002 film *Catch Me If You Can.*
In the above explanation, Ryan is referencing the 1999 science fiction film *The Matrix*, the premise of which is that what we experience as modern society is, in fact, a simulated reality that keeps us docile while intelligent machines harvest our bioelectrical energy. The film’s protagonist (“Neo”) is awoken from this state of artificial suspension after swallowing a red pill that another character (“Morpheus”) offers him, and Neo then discovers the true, horrifying reality of his life. In other words, MacDaniel (“basically the Morpheus to my Neo”) introduced Ryan to new theoretical lenses and knowledges that made it possible for him to reinterpret his adverse life experiences not as an isolated outcome of personal failings but as an outgrowth of broader social and historical processes.

Although the titles on MacDaniel’s bookshelf were diverse, Ryan was particularly transfixed by his friend’s copies of Thomas Szasz’s *The Myth of Mental Illness*, Phyllis Chesler’s *Women and Madness*, and a small collection of *Asylum* magazine issues that had been shipped from the United Kingdom. It was from *Asylum* that Ryan first discovered the existence of a movement called “Mad Pride” consisting of people who identified as “Mad” and militated against sanism. *Asylum* was (and is) an independent publication whose founders had been inspired by the U.K. anti-psychiatry movement but nonetheless sought to cultivate a unique audience that aspired not for reform but revolution. In a historical account on the magazine’s current website, an executive editor of *Asylum* indeed situates the magazine in opposition to the psychiatric consumerism that emerged in the 1980s and 90s, calling for a categorical end to the “the barbarism which has characterised psychiatric practices” and asserting that

> By the end of the millennium… networks were either falling into the clutches of the drug companies, becoming reliant on government funding or commercial operations serving the interests of the professional classes. *Asylum* could never do that. Yet the last decade in particular had seen the rise of a new generation of survivor workers and activists… Mad Pride internationally has recaptured the spirit of artistry and rebellion which was alive in the sixties… We will never have recourse to drug companies or sell out the principles of the radical democratic movement within and against psychiatry (McLaughlin 2007: para. 1-3, 5).

As we have seen, *Asylum*’s valorization of “artistry and rebellion” and its outrage toward those who fall “into the clutches of drug companies” and “government funding” are common themes in post-millennial Mad Pride discourse (and a recapitulation of some of the major debates outlined in chapter 3). However, for Ryan, the anarchic appeal of Mad Pride extended beyond its antagonism toward other activists’ co-optation. In his eyes, the Mad movement’s appeal lay primarily in its members’ refusal to bear labels like “ex-patient,” “consumer,” or even “survivor,” on the grounds that their experiences with psychiatry were, at best, incidental to their identities as Mad people. “I hate shrinks just like I hate millionaires,” he once pointed out,
but it’s normal, right, to hate people who hurt you. But here’s something—what it is, is if shrinks didn’t exist and there was no such thing as millionaires, the thing is, I would still be Mad. It’s just that rich guys and medical guys keep trying to kill me when honestly, you know, I’d just love to just, just to be free to live my life.

In short, Ryan’s contention was that his embodied unruliness and individuality predated his encounter with psychiatry and would outlast it; from his perspective, he was Mad neither because nor in spite of psychiatrists. As Linda Morrison has observed, the “difference that is being celebrated, then, in ‘mad pride’ is essentially the difference that is one’s identity before being labeled, and, in effect, after rejecting the label through resistance of psychiatric authority. This would allow celebration of the ascribed aspects of one’s own unusual identity or difference that attracted the attention of psychiatry in the first place” (2005: 168). However, Ryan’s denial that psychiatry had influenced his self-identity was not a denial of its influence on his life: he expressly attributed his daily suffering to both psychiatrists and the monied classes, whom he concatenated as complementary facets of a coherent whole (“rich guys and medical guys,” “I hate shrinks just like I hate millionaires”). And, as he later told me, his regular excursions to MacDaniel’s bookshelf had motivated him not only to become involved in Mad activism (and eventually to co-found the Unhinged group), but to become involved in anti-poverty activism as well. Ryan’s view that the poor and the psychiatrized were natural allies again came into sharp relief when he noted one day that

it is so consummately laughable that rich guys who are making eighty fucking grand a year are in, like, a position where they’re sending guys like us to budgeting classes and life skills workshops. I mean, what the shit is this? If you can get by on the scraps you get on, through, social assistance and ODSP, you should be fucking teaching those classes. But there is this assumption, right, that mad people and welfare bums don’t know anything, of course not, or they wouldn’t be in that situation.

Ryan’s animosity toward Ivy becomes somewhat easier to understand in the context of his life story. In a sense, Ivy was a walking reminder of the structural violence that had constrained so much of his life. She lived on her parents’ earnings in a beautiful house that they owned, whereas he had had to leverage his skills to gain an income and access to a tiny rental unit. Her wealth inoculated her from the indignity of being seen as financially inept and undisciplined, whereas he (or at least his peers, “guys like us”) could not escape accusations of irresponsibility. Firmly situated in the monied classes, she and her family were integral components of “the Matrix,” unable by virtue of their investment in the capitalist system to “see what the rest of us can see.” He was a rebel, a dissenter and lifelong transgressor—a cherished status that the bohemian Mad Pride movement had allowed him to reclaim from the humiliating jaws of psychiatry—whereas she chitchatted about sauce and sushi bars during challenging
political discussions. And yet she, the beneficiary of an economic system that had made his life so difficult, who had never so much as set foot on a psychiatric ward, dared to insist that she was “a survivor of something.” Were it not for his objections, she might even have successfully passed as a bona fide “psychiatric survivor”—a term whose usage Ryan jealously guarded even when rejecting for himself (“I fucking can’t stand that term,” see chapter 5). Worst of all were Ivy’s constant queries about his lack of a driver’s licence, which, in conjunction with her frequent offers of rides, served only to underscore the contingent quality of his autonomy.

In the months leading up to April, I found myself having some odd exchanges with Ryan, whom I began to suspect of looking for opportunities to demonstrate that his animus for Ivy was not about race. When she suggested, for the nth time, that I have my teeth straightened, Ryan cut her off. “How about you pay for the braces? Then she’ll get them,” he snapped, alluding to the exorbitant costs of orthodontic work and subtly highlighting the socio-economic gap between Ivy and me. Although I appreciate that he meant no harm, I was astonished by both his assumption that I desired orthodontic work and his presumption to make agreements on my behalf. During another exchange in which Olivia lamented the dearth of racialized participants in the Unhinged network and in the psychiatric survivor community more generally, Ryan interrupted by pointing at me and saying, with a wide grin, “Don’t worry, we have a spare.” The premise of his joke seemed to be that non-white individuals were somehow interchangeable, and I remember instinctively replying, “Wait, what do you mean?” He immediately picked up on my question’s subtext and denied its validity without either of us ever making it explicit (“No, no, no—” he laughed, “that’s not what I meant!”). I began to wonder if I was being too sensitive.

3.2 The Storm: “You’re Seeing Things that Aren’t There.”

In mid-April, I received a telephone call from Olivia. She invited me to attend a rally that would take place in Toronto’s Allan Gardens the next day at noon. The rally, called “Raise the Rates,” had been organized by the Ontario Coalition Against Poverty (OCAP) to challenge the potential elimination of a monthly dietary allowance from the Ontario Disability Support Program (ODSP). She explained that the demonstrators’ goals were threefold: to pressure the Ministry of Community and Social Services to retain the ODSP dietary allowance, to show the provincial government that the public would not tolerate further cuts to social services, and to advocate a 40% increase in current welfare and ODSP rates. The rationale for the third objective was that, since 1995, welfare and disability rates had been reduced in real terms by approximately 40% due to both provincial cutbacks and inflation; the demand for a 40% increase was therefore not
an expression of “entitlement,” as she put it, but rather an overdue call for the restitution of rates that were commensurable with Toronto’s economic climate. Because I had already made arrangements to help Ivy with some end-of-term essays the next day, I apologetically told Olivia that I would be unavailable and that I would see her at the next Unhinged meeting. However, within minutes of hanging up, I decided to phone Ivy to ask if she might be interested in attending the rally together either before or after our study session. While listening to the ringback tone and waiting for her to pick up, I felt naïvely optimistic that Ivy would agree to attend, due in part to the fact that she rarely missed Unhinged meetings. However, when she finally answered her cell and heard my idea, Ivy was less than enthusiastic. In addition to being astounded by my insinuation that something she considered a “social event” should take priority over her schoolwork, she was appalled at the demonstrators’ demands. “I don’t know,” she demurred over the phone. “I mean, forty percent is a lot of money for people who do nothing. Do you know what I mean?”

I was taken aback by her phrasing. However, I did, in fact, know what she meant, in that I was familiar with the arguments of rightwing pundits who routinely advanced similar claims, and I had often sensed that that Ivy’s claims of apoliticality—like most claims of apoliticality—were premised on the sort of hegemonic commonsense that made structural problems look like personal problems. In this sense, Ivy’s dismissal of the OCAP demonstrators as “people who do nothing” was not inconsistent with her diffidence toward politics. I agreed to stick to our original plans. Two days later, everyone on the Unhinged mailing list received an email from Ryan containing a link to an online Toronto Star column and a one-line message: “Are we going to this? Yes or no. Vote by Tues.” The Star column briefly described the mandate of an upcoming conference on “collective resistance against the theories and interventions of psychiatry” at the Ontario Institute for Studies in Education (OISE, the University of Toronto’s Faculty of Education; Henderson 2010: para. 6). The author, a prominent disability rights advocate, seemed sympathetic to the aims and objections of psychiatric survivors who sought “alternative approaches to... health and well-being” (Henderson 2010: para. 11), and the short piece consisted mainly of direct quotations from the conference website that were presented with minimal editorial comment. However, the only conferee whose participation was specifically foregrounded was David Carmichael, whose image appeared in the column’s sole accompanying photograph and whose story was featured in the column’s first five paragraphs:

Six years ago while taking the antidepressant Paxil, Toronto fitness expert David Carmichael took his 11-year-old son Ian to a hotel room in London, Ont., and strangled him.
The case shocked Canadians, highlighting concerns about possible behavioural changes related to drugs known as selective serotonin reuptake inhibitors.

Charged with first-degree murder, Carmichael was found not criminally responsible because of a mental disorder and transferred to the Brockville Mental Health Centre. On Dec. 4 last year, he received an absolute discharge from the Ontario Review Board.

The makers of Paxil, GlaxoSmithKline, have said they “do not believe Paxil played any part in this situation.” But what does Carmichael think?

Next month in Toronto, he’s scheduled to talk about his experience at a two-day meeting called PsychOUT, organized by people who believe that psychiatry’s emphasis on medical drugs and treatments can do more harm than good (Henderson 2010: para. 1-5).

No other biographic narratives or profiles were included in Henderson’s column. Thus, despite the fact that 56 sessions and over 70 presenters were listed on the conference program, and despite the fact that Carmichael was not one of the four advertised keynote speakers, the column was visually designed and textually organized to give the impression that his story exemplified PsychOut’s themes and aims (see Figure 7.1 in Appendix II). Moreover, by beginning with a description of Carmichael’s crime and segueing into his receipt of both a “not criminally responsible” ruling and an “absolute discharge,” the column had three subtle ideological effects: it reinforced the stereotype that the “mentally ill” are inordinately prone to violence, it fortified pre-existing public perceptions of excessive leniency in the Canadian justice system, and it thus encouraged a view of anti-psychiatry as a form of irrational opposition to para-judicial institutions that keep ordinary Canadians safe from harm. Given that the PsychOut organizing committee was readily contactable through their website, alternative portrayals of the conference were surely possible. As it stood, even if Henderson’s column was intended merely to present information about an upcoming event that happened to involve a discharged offender, its discursive construction served not merely to “locate sources of fear,” but to “also serve to remind people that they ought to be afraid” (Barker 2009: 269).

Over the weekend, replies to Ryan’s email trickled in. Two members responded in the affirmative, three responded with ambivalence (due to scheduling uncertainties and objections to the registration fees), and two responded in the negative (due to scheduling conflicts and

---

132 PsychOut took place on 7-8 May 2010. Presentations covered a range of topics, including children’s rights legislation, anti-rape activism, legal resistance strategies, the educational value of street art, adverse effects of drugs and ECT, the merits of online publishing, and the mechanics of song-writing. The conference’s official mandate was to “provide a forum for psychiatric survivors, mad people, activists, scholars, students, radical professionals, and artists from around the world to come together and share experiences of organizing against psychiatry” (PsychOut Organizing Committee 2010: 3). Although I was not involved in the conference’s initial planning stages, I was eventually enlisted by friends on the organizing committee to facilitate a panel on ECT and to read one of the keynote speeches when the actual speaker, Dan Taylor of MindFreedom Ghana, was denied a visa and barred entry to Canada (a common experience for African visa applicants; see also Diamond and Burstow 2011).
disinterest). On Monday night, Ivy, who was one of the last to reply, sent the following message to the group:

i dont buy it. he knew exactly wut he was doing. im not gonna see a murderer at a conference, k. thanx guys.

No one replied to her message for several days. Then, on Saturday morning, I opened my email account to discover a lengthy rejoinder from Ryan, in which he again alleged that she had violated the group’s safe space, called her “a sanist bigot,” and accused her of numerous moral failings, including ableism, classism, sexism, “fatphobia” and “anti-intellectualism.” He excoriated her for “thinking you’re so morally superior to the rest of us,” and derided her continual attempts to ingratiate herself with the others by “dangling your trinkets in front of us” and “bribing us with food, like we’re rats” (even though everyone took turns bringing food to meetings). However, he reserved particular scorn for her refusal to defer to those with firsthand knowledge of the influence that psychotropic chemicals have on users’ faculties of judgement and reason. In the lengthiest paragraph in his email, he condemned her “complete lack of compassion” for Carmichael and others who had “had their minds stolen and destroyed by drugs,” and then mockingly noted,

But then again what would you know about it? What do you have worth destroying? If they put you on Haldol today, who would be the wiser?

He closed with a warning (“do not under any circumstances think you understand what people like us have been through”) and signed his full name. I experienced a sinking feeling when I opened this email and saw the wall of text, and I braced for an angry exchange. Ivy did not reply until the next evening, when she sent a single sentence: “lol, ur not the only one who had a hard life, u know.” Ryan rejoined within minutes: “Sure, let’s hear the rich bitch with perfect teeth tell us all about how hard her life is.” Ivy did not respond. The next morning, we all received an email from Olivia, in which she urged the group to “put our differences aside” and chastised the entire psychiatric survivor community for its members’ tendency to “fight amongst ourselves instead of focusing on the real enemy -- psychiatry.” She pleaded for “unity,” and stressed the importance of maintaining “solidarity with ppl whose shoes we’ve never been in, and i mean that for both of you.” Later that evening, a reply rolled in from Yashar, who very rarely contributed to email exchanges. He opened with the phrase, “Dear Friends,” and explained that, although his work schedule made it impossible for him to attend meetings regularly, he considered the other members “close comrades and allies in the struggle for justice,” and he regretted chiming in “at this late hour,” which may have been a reference to the late stage of the conflict, rather than the
time of day. He commended Olivia for her plea for mutual respect, but gently observed that “calling for civility” is a technique that has long been used in social justice movements “to silence minorities” and that “for a white man to tell a woman of color to put up or shut up deals in some very problematic dynamics.” Ryan was unmoved. In his penultimate reply to this email thread, he remarked,

Dude, I love you, but I think you’re seeing things that aren’t there and I think you know I’m no racist. This is a group for PSYCHIATRIC SURVIVORS. We’re talking about a conference for PSYCHIATRIC SURVIVORS. You would never tolerate a White man telling you what is and isn’t true about your life or what is and isn’t possible in the lives of POCs [people of colour] and I wouldn’t blame you. I am saying as a PSYCHIATRIC SURVIVOR that it’s the same for us, we are the experts on our own lives. SSRIs cause users to lose control, you do and believe things you don’t normally do and believe, b/c it’s not you doing the thinking, it’s the drug. I am NOT directing this at you, but if you’ve never lived it you do need to put up and shut up and listen to those of us who have, b/c we go through life putting up and shutting up for fear of sanism.

Yashar’s reply was short but tactful: “I hear you. I just had to say my piece. Remember, I’m a psych survivor too. Peace.” Ryan’s response seemed to put the matter to rest: “I understand, bro. Peace.”

*   *   *

In the world of The Matrix, individuals are given magic pills that immediately sensitize them to the reality of their oppression. The transformation is instantaneous and absolute; characters are either asleep or awake. In the real world, the process of learning about social and historical injustices is considerably more complicated, and is neither instantaneous nor absolute. Just as the magic pills of our own world—antidepressants, anxiolytics, antipsychotics—cannot dissolve the accumulation of daily indignities and internalized insults that naturally give rise to feelings of despair and madness, scholarly books and progressive newsmagazines cannot inoculate readers from the unconscious prejudices that give rise to structural and symbolic violence. We are all complicit. However, it is sometimes the case that those of us who believe ourselves to be well-read, well-spoken, and politically active also believe ourselves to be more able to detect injustice—and more qualified to rule on the validity of allegations of injustice—than those who are deemed uneducated and or ignorant.

When Ryan chastised Ivy for yet again refusing to accept the truth claims of those who had experienced the deranging properties of psychotropic chemicals firsthand, I felt he had a point. I was, at that time, confused about why this one issue so disturbed and enraged Ivy when so many others did not (e.g. her dismissal of the OCAP demonstrators as undeserving “people who do nothing” just days earlier). Moreover, Ivy’s continual, vehement rejection of the idea that chemicals could influence behaviour seemed disproportional in light of her own admission that
she had never taken a psychotropic drug. However, in hindsight, Ryan’s management of the unfolding situation could also be read as disproportional to the initial offence, in light of the overwhelmingly superior social and linguistic resources at his disposal. As Butler (2002) has found, debaters who are able to frame their stances as more just, more principled, and more evidently grounded than their opponents’ are more likely to have their views ratified by listeners; when credibility is at stake, a speaker’s apparent fluency or dysfluency can be determinative. That the salient issue here is articulateness rather than accuracy is underscored by Ivy’s failure to follow up on her retort to Ryan’s accusations of hypocritical arrogance: she asserted that she, too, had “had a hard life,” but ventured no further counterargument when Ryan immediately mocked her with the “rich bitch” line. She then lost or abdicated her status as his primary interlocutor during the ensuing flurry of emails, which swiftly turned to other topics: Olivia’s call for a united front against psychiatry (“the real enemy”), Yashar’s reminder about historically problematic patterns, and Ryan’s effort to reorient of the debate around the psychiatric survivor/non-survivor binary, which required him to claim a label that he loathed (“psychiatric survivor”) in order to thwart Yashar’s line of argument. The email thread’s conclusion—Yashar’s and Ryan’s reciprocal valedictions of “Peace”—terminated the debate before a resolution to the original query could be reached (“Are we going to this? Yes or no”) and foreclosed any likelihood that Ivy would regain the floor. Ivy’s silence, however, does not have to be read as acquiescence or even indifference. As Deborah Tannen (1985: 97) has noted, “If indirectness is a matter of saying one thing and meaning another, silence can be a matter of saying nothing and meaning something.” Sometimes, silence is the loudest form of protest.

Implicit throughout the above exchange is the assumption that there is a clear, binary distinction between those who are in their right minds and those who are not: David Carmichael either did or did not know “exactly” what he was doing, Ryan either is or is not “a racist,” Ivy either is or is not “a sanist bigot,” and the psychiatric survivor community either is or is not duly united against its “real enemy.” As previously noted, dichotomous truth claims about social justice and psychological soundness often conceal more than they reveal. Not only is it untrue “that in every culture a normal, healthy self will be internally coherent and relatively well

---

133 To be fair, Ivy was not the only member of the Torontonian anti-psychiatry/psychiatric survivor community who objected to David Carmichael’s inclusion in the conference program. For example, Helen (with whom I attended Carmichael’s Mad Pride lecture in 2009) called his inclusion “highly inappropriate,” whereas Cassidy felt it was simply “bad publicity.” Both had learned of his inclusion from reading the Star.

134 Indeed, the Unhinged members did not ultimately attend PsychOut as a group, and, as far as I have been able to determine, only two members participated in the conference.
integrated” (Boddy 1992: 325; see also Lambek 1992, 2010), there is, as suggested earlier, an enormous amount of overlap in the attitudes, values, and priorities of the “sane” and the “mad” in our own culture. In episodes like the one depicted above, therefore, what is at stake is “not just who gets labeled as violent but who gets to define violence” (Sone 2003: 10). Ivy insisted that Carmichael’s violence against his son must not be sanctioned, while Ryan counterargued that the violence that was most relevant from a psychiatric survivor viewpoint was that which had been inflicted on Carmichael’s mind (“stolen and destroyed by drugs”), and Yashar contended that Ryan’s attitude toward Ivy itself comprised a form of institutional violence. While Yashar did not explicitly use the adjective/noun “racist,” Ryan immediately parsed his friend’s observation about racially unequal practices as an accusation of overt interrelational bigotry, thus giving himself an easy exit: to deny that he is a racist and imply that only the oversensitive could claim otherwise (“you’re seeing things that aren’t there”). What is significant here is not so much the question of whose view was more accurate, but the fact that racism—at least in the context of this exchange—came to be treated as a categorical quality that people either have or lack, rather than as an emergent, systemic process that shapes social outcomes (Brodkin et al. 2011). In an ironic twist on psychiatrists’ tendency to acquire professional credibility by writing clinical narratives that justify “the systematic discounting of the patient’s narrative” (Good 1994: 78; see chapter 6), Ryan’s skilful reformulation and demolition of Yashar’s critique served to authenticate his objectivity and bolster his credibility at the expense of his friend’s. What was left unquestioned and untroubled at the end of this exchange was the false dichotomy between rationality and irrationality that is common to accusations of both “mental illness” and “bigotry,” not to mention the various degrees of murder.

A final avenue through which psychiatric reasoning has smuggled itself into this debate is discernible in Ryan’s jab at Ivy’s intelligence (“If they put you on Haldol today…”). In the psychiatric survivor community, the drug Haldol is notorious for its debilitating effects on users’ physical mobility, mental agility, and verbal capacities. Former patients who have been on Haldol consistently complain of two humiliating side effects: it causes them to drool, as it inhibits peristalsis (the swallowing reflex), and it induces involuntary muscle tremors, thus making users appear as though they are “shuffling” when they walk (Shimrat 1997, see also chapter 6). When Ryan wryly implied that this state—drooling and shuffling while physiologically immobilized—so closely resembled Ivy’s natural of being that none “would be the wiser” were she to take Haldol, and when he suggested that there was nothing in her mind “worth destroying,” he was not only calling her stupid, but insinuating that some minds are
worthier of protection than others. It is true that the jab was designed to hit where it hurts, so to speak; we all say things in anger that we otherwise might not. The insult nonetheless acquires another layer of significance when we recall a key tenet of the Mad Pride ethic: the contention that madness and genius are one and the same, and that the quintessential Madman throughout history has always been the persecuted artist-musician-savant who just happens to also be, by common agreement, white and male (Hemingway, Cohen, Cobain, Beethoven, Schumann, Van Gogh, etc). While Ryan undoubtedly did not intend to racialize the discussion, intent is not a prerequisite to effect: his insult was an efficient reminder that not everyone is fluent in the cultural styles that we equate with “our” society’s intellectual and artistic heritage. Ivy—whose emails were riddled with non-standard spellings, whose input during meetings was rarely topical, who did not participate in the group’s creative writing sessions—had consistently failed to live up to the canonical standards of Madness, and Ryan was letting her know that she was on notice.

But if psychotropic drugs “steal and destroy” people’s minds, should it matter that some of those “stolen and destroyed” minds belong to people with no interest in, or no aptitude for, certain genres of music, literature, and art? What difference does it make whose mental faculties are at stake? Here, the romanticizations of intellectual virtuosity that permeate Mad Pride discourse reveal their eugenic undertones: to take for granted that madness and creativity are one and the same is to confuse description with prescription. Because Unhinged consisted primarily of white, Canadian-born native speakers of English who enjoyed creative writing and had experienced psychiatrization in similar ways, Ivy’s distinctive traits—her wealth, her blunt evaluations of others’ appearances, her preference for cementing social bonds through culinary rather than locutionary acts, her prioritization of homework over poetry, her apparent indifference to Ryan’s taunts—may have come across as aloof, even condescending, rather than as indicative of life experiences that reflect non-Western relational norms. It was, perhaps, precisely because her behaviour conformed to longstanding stereotypes about emotionally remote Asians whose natural studiousness confers unfair advantages in competitive settings—leading, for example, to undeserved wealth (Gilmour et al. 2012)—that she became, in Ryan’s eyes, not a fellow casualty of society’s definitions of good conduct, but a beneficiary of it. The fact that no one challenged Ryan on his Haldol taunt is a rich illustration of Ray McDermott’s insight that “Inarticulateness is a dance in which we all engage, either by suffering it ourselves or by arranging for others to carry the burden” (1988: 44). While all criteria for evaluating intellectual proficiency are arbitrary, the penalties that accrue to those who fail to meet them are very real. To systematically defer to those who have mastered the appearance of eloquence and
assertiveness is to be complicit with the hierarchies of credibility that lead others to seem stupid, inelquent, and limited by comparison—in a word, “feebleminded.” And to cloak such unequal practices in a language of class persecution, in which militancy is endorsable only when it serves the interests of the iconic male subaltern (Roy 2008), is to invite those whose interests diverge from this standard to find the nearest exit.

3.3 The Fallout: “Welcome to the Club.”
I want to remind readers that the type of conflict depicted above is not unique to the anti-psychiatry/psychiatric survivor context. Because people internalize structural and symbolic violence in subtle ways, vicious episodes of infighting can at first glance seem bizarre, and, in the absence of sufficient theorization, can seem solely attributable to disputants’ psychological instabilities. However, anyone familiar with the internal dynamics of a labour union or other social justice organization will likely be able to recount similar stories about the gap between progressive agendas and members’ actual behaviours (see Chong 2008). It is also important to remember that, if my fieldwork year had begun and ended earlier, or if I had employed a research method that did not require me to monitor my informants’ lives other than during formal interviews, I might have missed out on the above events and my ethnographic portrait of the Unhinged group might be rendered in more harmonious hues.135

Caveats aside, it is an unalterable fact that Unhinged disintegrated rather quickly following Ryan’s dispute with Ivy and Yashar. To omit an account of the group’s demise, even if only to avoid reinforcing invidious stereotypes about dysfunctional mental patients, would be to betray my informants’ depth of conviction about patterns of inequality they could no longer countenance. A few days after Ryan contributed the last message to the above email thread, Olivia emailed the group to confirm the next Unhinged meeting. Within the day, we received a poignant letter from a long-time member and regular attendee, who stated that he didn’t “want to be part of a club that can’t even see when its own members are uncomfortable,” and that he was now “in a different place in my life,” and no longer wished to be a part of the group. I later followed up with this member, who told me forthrightly that Ryan’s failure to consult him—a former Paxil user—about Paxil’s volitional side effects prior to defending David Carmichael on the listserv was painful and alienating. “He doesn’t speak for me,” this member asserted. “I know what Paxil does to you. It makes you fat and it makes you sweat. It makes you hate yourself. It doesn’t make you kill.” When I pressed him on this point, he specified that he could accept self-
harm, suicide, and property destruction, but never homicide, as side effects of Paxil. Ironically, Ryan was now being critiqued for precisely the transgression that he had accused Ivy of, namely the failure to defer to those with greater firsthand knowledge. Ryan, who had been on Zoloft but not Paxil (both are SSRIs), was suddenly the one who the lacked the experiential credentials to speak with authority.

Early the next morning, we received Yashar’s farewell letter. He explained that “there’s too much going on in my life,” citing work and family obligations, and noted that he could no longer guarantee further participation in Unhinged. He then signed off amicably and with a message of solidarity. In short, he attributed his need to “step away” from the group entirely to pressures and stressors in his own life. I did not know Yashar nearly as well as some of the others, but, when I later followed up with him to inquire about his departure, we ended up having a long lunch during which we exchanged hilarious anecdotes about our lives as Canadian-born non-whites. In a particularly insightful monologue, which was not directed at any individual member of Unhinged but rather at the broader anti-psychiatry movement, he discerned a fundamental problem in movement leaders’ constant lamentations about unequal racial representation:

> You get a constant sense from these people that they just want more coloured faces at the demos, so they can feel they have the support of a large segment of the society. Well, you can’t spearhead a revolution when you were—when you are—fine with power when it’s doing right by you. … Before mighty whitey found himself in a straitjacket, there were other kinds of chains too, right? For us, it’s like, yeah, degradation and dehumanization really, really suck. Welcome to the club.

Yashar explained that while his own experience with psychiatry (six months on a course of antidepressants and mood stabilizers that gave him headaches, nightmares, and high blood pressure) had been “unpleasant,” it was “nothing” in comparison to the daily indignities of being seen and treated as a perpetual foreigner in his own country. Moreover, it was precisely the continual frustration of having to adhere to the stoic archetype of the culturally assimilated racialized Canadian—who, like white Canadians, does not “see” race in every untoward incident—that accounted, at least in part, for his ongoing feelings of outrage and depression. In his view, white political activists were among the “worst offenders” when it came to enforcing this imperative (“you have to watch your back, cause all they want is your face in the newsletters and the moment you want a say, they are going to close ranks… they are going to accuse you of

---

136 The stoicism of this stance lies in the fact that racialized Canadians who adhere to this norm often do see race in untoward incidents, but must (or are expected by their white colleagues to) refrain from drawing attention to it. Such expectations of course fortify stereotypes about overly sensitive people of colour who have chips on their shoulders and pick fights unnecessarily (e.g. the stereotype of the “angry black man,” Wilkins 2012).
Seeing things”). Although he did not illustrate this latter observation with any specific examples, his words closely mirrored Ryan’s earlier admonishment (“I think you’re seeing things that aren’t there”) and he may have had it, or other incidents like it, in mind when formulating them.

In short, for Yashar, psychiatrization and racialization were continuous with each other; both relied on historically entrenched tropes about the exotic mentalities of darker skinned, flatter nosed peoples whose rationality is impaired by “vanity and immaturity” or a “pathological sense of honor” (Anderson 2006: 141; see chapter 3). The fact that many white survivors were knowledgeable about historical patterns of violence did not prevent them from, on the one hand, displaying insatiable curiosity about where his parents had immigrated from, what his ethnic background was, where he had been born (demonstrating that they saw him as indelibly Other) and, on the other hand, denying that race was ever a salient factor when interactions went sour (suggesting that only they could reliably make this determination). He stressed that Ryan, Olivia, and the others were compassionate individuals with “solid politics,” but, in his only allusion to his electronic dispute with Ryan, he stressed also that some people forget that being a psych survivor doesn’t mean the same thing to everyone, and that, it’s like, being seen as a brown person first and a survivor second is a particular kind of mental violence.

In this statement, Yashar pointed out a rather invidious assumption on Ryan’s part: that his defence of Ivy could only have stemmed from an instinctive allegiance to a fellow person of colour (“being seen as a brown person first”), a dehumanizing premise that reserves individuated thoughts and motivations for white, Euro-American speakers. Pressed by Ryan to choose between his psychiatrized and racialized selves—with whom would his loyalties lie?—and suddenly aware that he was “entitled only to drown in an anonymous collectivity” (Memmi 1967: 88), Yashar felt he had no choice but to disinvest from a dilemma he found disagreeable.

When I asked him if he was stepping away from anti-psychiatry altogether, Yashar indicated that he had limited time and energy, and that, “on balance,” anti-psychiatry was not the political cause about which he cared most. That distinction was reserved for the antiwar movement.

* * *

Yashar’s grievances map closely onto Megan Vaughan’s (2001) account of the revelation that Frantz Fanon experienced while volunteering for the French Armed Forces during World War II. Although Fanon had been immersed in French culture throughout his upbringing, upon “stepping onto French soil he discovered, with a sudden and irreversible shock… that he was, in French eyes, nothing more than a ‘black man’, a ‘Negro’” (Vaughan 2001: 10). Fanon’s later
theorizations of the permanent alienation to which racialized people are subject, not only under the colonial boot, but while wearing it, are indeed germane to a deeper point here: psychiatric survivorship is not a unitary experience, and, if psychiatry is not only a medical institution but a web of cultural discourses, vocabularies, tropes, and narratives in which we are all steeped, then enduring others’ relentless attempts to remind one of one’s Otherness may also be to survive psychiatrization. To slip away in order to spare one’s sanity—and to do so politely, so as not to offend the close friends who happen also to be one’s psychiatrizers—is to exercise a quiet form of negative agency that signals dissent without incurring the energetic costs of overt conflict.

After Yashar sent his email to the group, Ryan announced an “emergency meeting” for the coming weekend. Ivy was not copied on the email. At the meeting, which five people attended, Olivia indicated that the departure of the first member who had sent a farewell email (who didn’t “want to be part of a club that can’t even see when its own members are uncomfortable” and who felt hurt by Ryan’s failure to consult him about Paxil’s adverse effects) had been “a serious blow” to the group. She urged everyone to “pull together” and to feel free to “call us out” on lapses of judgement like the one that Ryan had demonstrated when he had forgotten that this member was a former Paxil user. She then turned to the topic of Yashar’s departure by pointing out that the psychiatric survivor community “is already too monochrome as it is” and that the group need to try harder to identify and recruit racialized candidates for membership. In other words, she ratified the first member’s departure as a legitimate reaction to a silencing social dynamic, while Yashar’s departure was parsed only in terms of the presence/absence of non-white members in a “monochrome” community.

A major reason for this, of course, is the fact that Yashar had always been an irregular attendee of Unhinged sessions due to a wide range of occupational and familial obligations. While the other members knew this, they could not have known of his other existential grievances about white activists, because he had never told them. Hence, their understanding of his departure was limited to their knowledge of his need to budget his time carefully and his inability to devote multiple hours each month to extracurricular activities. In this sense, Olivia’s declination to frame Yashar’s departure as anything other than an individual issue (“he’s busy”) was understandable. Nevertheless, Yashar’s preoccupation with work and family responsibilities was also shaped by broader social and geographic determinants that were specific to his racial positionality. As Brodkin et al. (2011) observe, racialized members of the workforce are frequently faced with caregiving duties that extend far beyond that of the nuclear household and that often transcend national borders (see also Glick Schiller and Fouron 2001). My point here is
not that Olivia, Ryan, and the others should have found a way to accommodate Yashar’s schedule—indeed, that would have only placed more pressure on him to attend meetings—but that the underrepresentation of racialized constituencies in anti-psychiatry cannot be rectified through individualistic solutions that conflate “representation” with “equality.” To treat a non-white face as a placeholder for racial diversity, and to treat its absence as a concomitant absence of diversity, is to assign tacit blame to the owner of that face when he or she fails to participate and, thereby, sabotages a group’s multichromatic aspirations. It is also to be complicit with the social structures that inflict subtle and continual violence on racialized people’s mental health.

There had of course been another racialized member in Unhinged—Ivy—who had attended meetings with far greater frequency and enthusiasm than Yashar. Ivy’s exclusion from Ryan’s “emergency meeting” email did not go unnoticed. MacDaniel, who had co-founded the group but had left two years earlier (chapter 6), was in attendance that day at Olivia’s request. He was, in his characteristic way, quiet throughout most of the ensuing discussion, which centred around the question of how to recruit new members. However, at a certain point, he decided to point out the strange nature of the group’s dilemma:

Let me see if I understand your problem. You want more minorities but you don’t invite the one you already have?

Ryan, who always had enormous respect for MacDaniel’s views, seemed hurt by his insinuation that Ivy’s exclusion had a politically malign significance. He stressed that Ivy had never been interested in political conversations (true) and that she had no opinion on this topic (undetermined). He then looked directly at me and said, “Besides…,” trailing off and perhaps implying that my presence somehow compensated for Ivy’s absence. MacDaniel chuckled, perhaps a sign that he understood the flaw in Ryan’s implication. However, he did not problematize his friend’s stance any further. Like Ivy, he did not consider himself a political activist. And, although prodigiously well-read, he had always preferred to stay out of debates.

In the end, the group decided to take a summer hiatus. It did not reconvene in the fall, due in part to the fact that key members were hired into new jobs with inflexible work schedules and/or became preoccupied with schoolwork with the start of the new academic year. The group in fact never reconvened. Alyssa, who had always considered herself an “ally” rather than a “survivor,” looked elsewhere for a creative writing group. Olivia and Ryan still hang out regularly with their friends Richter and Ashley, although they no longer use the “Unhinged” name or listserv. I saw Melinda only once after the group’s dissolution (see chapter 5) and have no idea where she is now. Ivy, whose initial participation in the group had been motivated by her
enthusiasm for “a group of people you can be yourself with and not care,” never returned to the fold, having discovered the inextensibility of this principle to the ideologically impure.

* * *

In early July, I reconnected with Ivy. She had distanced herself from me following the events in April, possibly due to my continuing association with Ryan and Olivia. In the intervening weeks, I had been too consumed with other aspects of my fieldwork and with medical matters (steroid psychosis) to re-establish contact. When the summer heat kicked in and I realized my fieldwork year was drawing to a close, I felt obligated to get to the bottom of Ivy’s unshakeable rejection of the idea that psychotropic chemicals could alter a person’s volitional faculties. So, I phoned her and we arranged to meet at Pacific Mall, where she planned to purchase some accessories for her car. As we patrolled the sparkling glass and granite interior of the retail centre, sipping tall cups of tapioca tea, my mind kept replaying images that I had seen in the news of demonstrators at the recent G20 economic summit in Toronto being herded into the backs of vans, chased by mounted police officers, and beaten with nightsticks. Ivy chattered away at my side, gesticulating at the mannequins that lined the storefront displays and ridiculing the outfits that adorned their plastic torsos, and I began to wonder what caustic remark Ryan might make about our complicity in the economic status quo. We sat down on a bench, and, while wiping the condensation from her cup, Ivy said, “You wanna know something that really upsets me?” I replied in the affirmative. What upset her, she explained, was the fact that the Unhinged members had been “always going on and on and on about justice,” and yet had failed to detect a “big, fat justice problem right in front of their faces.”

Like, if you say a guy is drunk, right? So he goes and frickin’ kills his kids or, like, kicks his baby in the face. It’s not, like, some alcohol in his brain that does it. Do you know what I mean? It’s like when your drunk ass husband beats you up and it’s like, he goes, ‘Sorry, babe.’ You get beat up and he’s, like, he gets away. [Eugenia: Well, sometimes.] Exactly! Cause you can say, well, fuck you, fuck you very much. Do you know what I mean? Your life doesn’t mean, like, my life gets wiped out [rendered less important]. Parents don’t own their kids. … I just get so angry. Cause it’s like, some guys are always getting away with things, and, like, I can’t. I can’t say, oh, my life is so hard, just cause I grew up in a way where I didn’t get drugs. So, it’s not ok for me, if I go, like, oh, the reason I killed that guy is cause I got tired of like,
putting up with his bullshit, like if he’s always making fun of me, but if he kills me, it’s ok, cause he’s on drugs. Like, that makes so much sense.

The above excerpt is a powerful illustration of McElhinny’s (2001: 67) insight that inarticulateness is “an institutional and situational artifact bound up with issues of power rather than… a psychological description.” While it is clear that Ivy is struggling to mobilize the words she needs to articulate her thoughts, she displays a formidable resistance to seeing her dispute with Ryan as either solely her fault or the fault of others, and begins to develop a sociological analysis. On the surface, the thrust of her argument seemed to be the very neoliberal complaint that too many excuses are available to those who violate the laws of civil society. However, her intensive effort to unpack the determinants of violence tapped into a rich array of etiological frameworks: alcoholism, gender stereotypes, patriarchal ideologies around the ownership of children, and the countervailing tensions between structure and agency that lead to the mystification of some forms of violence and the legitimation of others.

Her anguish over her disentitlement to the moral latitude that Ryan repeatedly offered Eric Harris and David Carmichael was complexly layered: in her last sentence, she rejected the sanity/madness argument so frequently deployed in courtrooms and newsrooms, and instead called attention to the injustice of punishing “sane” people who retaliate against their victimizers (e.g. snapping after enduring one too many insults) and exculpating “insane” people who abuse others while drunk, high, medicated, stoned, or otherwise “altered” (“if he kills me, it’s ok, cause he’s on drugs”). By ridiculing the categoricity of this distinction, Ivy brought a central issue of this debate into focus: the fact that violence operates on a continuum on which historical trends, socioeconomic forces, and gendered inequalities inform each other, leading—for example—men to feel entitled to beat their female partners, parents to feel entitled to make decisions about their children’s lives, and bullied boys to feel entitled to avenge their emotional injuries. Ivy, in other words, was the only member of Unhinged who recognized why madness/sanity debates were so dangerous: constructs like “SSRI psychosis” and “not criminally responsible” conveniently mask the fact that, even if undertaken in an “altered” state, the crimes of school shooters, abusive men, and well-intentioned parents who seek to end their children’s hypothesized pain conform to culturally sanctioned narratives about justifiable and unjustifiable acts, not to mention worthy and unworthy victims (e.g. entitlement to take revenge on one’s emasculators, entitlement to treat women, children, and the disabled as property). These individuals may not be responsible for losing control, whether over their actions or over their perceptions. But who is responsible for scripting their performance?
Ivy’s offhand remark about the challenges of finding ratification for the adversity in her life (“I can’t say, oh, my life is so hard, just cause I grew up in a way where I didn’t get drugs”) referred to her having suffered through “mental illness” without professional support, due to her parents’ disdain for psychiatry and its constructs. When we recall that Ryan’s attacks on her were largely reducible to the claim that rich people cannot have—as she frequently put it—“tough lives,” and when we recall that poor people tend to be at greater risk of forcible medication or hospitalization (Rabinowitz 1994), her remark also becomes a stark reminder of the fact that while money can forestall official psychiatrization, it cannot forestall pain, depression, or despair. As Julie Livingston (2009) has argued, there are times when money can in fact amplify pain, serving as a mocking reminder that financial capital is no substitute for relational, social, cultural, or political capital. Given that Ivy’s initial rationale for her devotion to Unhinged was that it offered her a place to be herself and to meet others who understood firsthand what it was like to be “crazy,” it was a bitter irony that her family’s disbelief in psychiatry—and her resultant avoidance of virtually all contact with official psychiatrization—served to delegitimize her opinion on the Carmichael tragedy. In a certain sense, she had been the first of the Unhinged members to possess an “anti-psychiatric” (or, at least, a non-psychiatric) outlook; her and her family’s dismissal of biomedical psychiatry is common among first generation Canadian immigrants (a fact that routinely leads the government to issue plaintive calls for mental health education in immigrant communities, Whitley et al. 2006; see e.g. Mental Health Commission of Canada Service System Advisory Committee 2009). That is, Ivy’s experience hewed to a pattern that is characteristic of the ways in which many racialized Canadians encounter, and counter, psychiatry. Her disqualification from the “psychiatric survivor” identity label is thus no accident: it is an indication that many racialized people experience psychiatrization in non-canonical ways that the contemporary psychiatric survivor community may not currently recognize.

I paid little attention to the subtleties of Ivy’s arguments about volition and violence while sitting on that mall bench, and I did not begin to grasp the sophistication of her position until I later replayed her recorded words. However, I did pay attention when, later that afternoon, she asked me to explain “all this G20 business” to her.\footnote{On 26-27 June 2010, the fourth annual G20 economic summit was held in downtown Toronto. According to the Office of the Auditor General of Canada, “more than 20,000 police, military, and security personnel” were involved in policing the summit (2011: 8). In the largest mass arrest in Canadian history, 1,118 people were arrested during this event, 70 of whom were arrested while sleeping in the Graduate Student Union’s facilities at the University of Toronto (Morrow 2011, Popplewell and Lu 2010). Although a small percentage of demonstrators engaged in property destruction, the majority of arrested individuals were peaceful demonstrators and even non-demonstrators who simply happened to be passing by. The news media helped to legitimize the high arrest rate by popularizing a} I surmised that she had been following
news coverage of the protests and so I summarized the issues as best as I could. She listened patiently to my synopsis, and then remarked, “Those guys are probably there,” referring to her erstwhile friends from Unhinged. I acknowledged it was a likelihood. “I guess they don’t deserve that,” she murmured, thinking, perhaps, of the multiple forms of violence being inflicted on all of those “people who do nothing.”

4. Other Kinds of Chains

“However uncomfortable the fact may be—and it is very uncomfortable—society isn’t neatly divided into two groups, mad and normal. And the attempt to create a neat division is precisely what leads to prejudice, as the “sane” rush forward to distinguish themselves from the mad.”
(Allan 2006: para. 10)

In a recent study of racialized anthropologists’ experiences in American academia, Brodkin et al. (2011: 550) found that most “universities and departments within them conceptualize racial diversity as a general social good rather than as integral to the intellectual strength or mission of graduate and professional life.” Despite their white colleagues’ advanced training in cultural analysis, Brodkin et al.’s informants spoke of having to “walk on eggshells” when challenging racially unequal practices and even of being told that “it was not good for an Amerindian to teach about Indians as there would be a problem with objectivity” (2011: 553, 551). I want to suggest that Brodkin et al.’s insight about academe’s inability to make the leap from seeing “racial diversity” as an abstract virtue to seeing it as inseparable from analytic rigour may also be applicable to anti-psychiatry’s chronic inability to attract racialized contributors. As we have seen, despite white psychiatric survivors’ earnest commitment to the general cause of social justice, their versatility with an impressive range of critical vocabularies, and their recognition that certain constituencies are underrepresented in their movement, their racialized counterparts still became alienated. Faced with the implicit demand to wear only one of two possible hats (“psych survivor” or “brown person”), Yashar felt compelled to disengage from a group whose nominal “safe space” did not extend to him. Stigmatized by mainstream society and unqualified for psychiatric survivorship by conventional definitions, Ivy found herself in the untenable position of being too much of an outlier to navigate either set of norms. Both, in time, were led to non-existent law that supposedly authorized police to detain anyone within five metres of the summit venue’s fenced perimeter (CBC News 2010b). Many detained individuals were denied access to legal counsel and adequate nutrition for more than a day (Morrow 2011, personal communication with participants). In early 2012, forty-five police officers were charged with misconduct; public inquiries into other aspects of the above events are ongoing (Dubinsky and Seglins 2012).
conclude, as Renee Martin had, that “camaraderie lasts only as long as you don’t insist on interrogating oppression from multiple sites” (2010: para. 3-4).

Ryan, too, was a casualty of power relations that shed light on certain forms of violence while obscuring others. His outrage at Ivy’s repeated denials that SSRIs usage could be linked to homicide did not justify his callousness, but it was, at minimum, understandable given that Unhinged was meant to be one of the few spaces where former antidepressant users could discuss such matters freely. Moreover, when he initially became politicized, he could do so only through the lens of his own life history, in which he had found himself alienated from family, clinically detained on the basis of a transgressive activity that was central to his sense of self-worth, and relegated to the margins of society even when gainfully employed. If we recall Hannah Arendt’s “principle of minority politics, that ‘one can resist only in terms of the identity that is under attack’” (1968: 18, quoted in Dave 2011: 660), Ryan’s subsequent turn to both Mad Pride and anti-poverty activism becomes legible as a visceral pronouncement that he is poor and Mad—and literally mad—and not just white and male. Nonetheless, given that “one of the routes through which material disadvantage affects behaviour and health is through people’s ability to construct a sense of identity and purpose under very difficult social and economic conditions” (Williams 2004: 285), it is unsurprising that his lack of class privilege led him to overexert cultural privileges to which he did have access when attempting to silence Ivy and outdebate Yashar. Ryan’s reaction may appear less sociopathic when we remember that to be impoverished, psychiatrically stigmatized, queer, and yet accused of being an oppressor would be a difficult experience for someone with few or no pre-existing reasons to confront his own complicity in the status quo. Just as the “sane” may leap too quickly to distinguish themselves from the “mad,” white “Mad” activists who have never needed to cultivate an anti-racist outlook may leap too quickly to distinguish themselves from the “sane”—coming to see themselves as uniquely downtrodden, or, in the words of MindFreedom’s Executive Director, “considered inferior in our most basic essence—our chemistry, our genes” (Oaks 2010: 5). The claim that sanism is the worst “-ism” erases the experiences of entire continents of people who, in resisting their colonizers and pathologizers, forged some of the first links in the anti-psychiatric struggle.

I want to conclude by suggesting that, contrary to received wisdom on the Left where infighting is widely lamented as counterproductive, there is considerable ethical merit to internal conflict in social movement communities, and that to prioritize solidarity and unity at all costs is to uphold some very deeply psychiatric assumptions about the nature of health and normalcy. Throughout this thesis, I have tried to explore some of the ways in which suffering can incite
outrage, indignation and the desire to initiate radical changes in both one’s life and one’s society. Contrary to mainline conceptions of mental health, roiling internal conflicts and psychotic breaks can be healthy and necessary when one is faced with debilitating social pressures that strongly hint toward the existence of hidden power structures. Pain tells us that something is hurting us, and strife allows us to test our assumptions. This is true for both psyches and communities. To gain insight (no pun intended) into the cultural forces that are leading so many of us into doctors’ offices in search of prescriptions, we must unmoor ourselves from the notion that comfort and security are synonymous with dignity and justice. Whether psychological or political, artificially maintained harmony may facilitate the former but often impedes the latter: just as Ryan’s politicization was enabled by and not despite his firsthand immersion in pain and poverty, Ivy’s eventual formulation of a proto-sociological analysis was enabled by and not despite her estrangement from the other survivors. To push uncompromisingly for productive normalcy or political unity at all costs is to encourage those who can neither defer in good conscience nor find an audience for their dissent to quietly slip away while feigning agreement. Likewise, to gain a richer understanding of the factors that lead people to commit terrible acts of violence, we must unmoor ourselves from mystifying lenses like “psychopathy”—or even “mind-altering drugs”—and consider how pre-existing social norms and narratives, to which we all contribute, offer expedient scripts for the expression of brutality. We also need to ask why some forms of harm and self-harm matter, and come to be explained in terms of pathology, while other forms do not.
Chapter 8
Rethinking Normal: Conclusions and Directions for Further Inquiry

While working on my final dissertation chapter in the summer of 2012, I began encountering some strange advertisements in the city’s transit system, which were paid for by the Centre for Addiction and Mental Health (CAMH), and which showcased denialistic stereotypes about “mental illness,” along with certain kinds of counterarguments:

“IT’S ALL IN YOUR HEAD.”
OR AS WE’RE DISCOVERING, YOUR BRAIN.

“YOU JUST NEED A CHANGE OF SCENERY.”
MAYBE IT’S A HOSPITAL.

“WHAT YOU REALLY NEED IS A NIGHT OUT.”
OR, IN SOME CASES, A 21-DAY STAY.

“DON’T WORRY, IT’S JUST A PHASE.”
BUT FOR SOME IT CAN LAST A LIFETIME.

“MAYBE YOU JUST NEED A DAY OFF.”
LIKE THE HALF MILLION CANADIANS THAT MISSED WORK TODAY WITH A MENTAL ILLNESS.

By papering the city with these ads, CAMH intended to “challenge people to re-evaluate their own outlook on mental illness, and give them a better understanding of who CAMH is and what we do” (Centre for Addiction and Mental Health 2012a: para. 3) and the ad campaign was doubtlessly meant to raise awareness about, and convince doubters of, the reality of psychological distress. However, during its weeks on the city’s transit shelters and subway platforms, my inbox exploded with outraged emails from local psychiatric survivors—the very constituency that CAMH sought to support—urging each other to write letters of complaint to the Toronto Transit Commission and major newspapers. One email called the ads “stigmatizing and demeaning… They take a cheap shot and we want to take action to address this.” Another email consisted of a single sentence: “the ads are truly disgusting.” Some set out to create stickers with which to modify the lines recommending hospital stays,139 the proposed wording of which would include the rejoinders, “S&M aficionados will enjoy the restraints and the humiliation! A free diagnosis complete with your very own label!” Others proposed to add the editorial remark “Citation needed” to the assertion that “for some it can last a lifetime.” In a

139 It has been pointed out to me that the second and third slogans listed above may have been intended to challenge the assumption that mental illnesses require hospitalization. However, this reading is belied by written explanations at the bottom of these ads, which openly invite hospital stays, e.g. “It’s hard to dismiss a mental illness or substance abuse problem when the person struggling desperately needs help. …This is why CAMH offers 24/7 emergency services. But, just as importantly, we are dedicated to providing ongoing care and treatment at our many facilities. Our new Queen Street buildings create an environment for healing and recovery” (CAMH 2012b). Admittedly, these statements appear in a small typeface that is eclipsed by the ads’ main phrasing (see Figure 8.1 in Appendix II).
phone call, Olivia expressed disbelief at CAMH’s insinuation that it was somehow ignorant to advise the “mentally ill” to seek out therapeutic avenues such as “a change of scenery” or “a night out” in the company of friends—both of which she far preferred to the “drugs and [electro]shock” she had endured during her own hospitalization. Richter and Fleming invited me to accompany them on a citywide excursion to deface the ads with thick Sharpie markers. Cassidy—who, of all of my informants, was always the most accepting of biological explanations—fumed at the declaration that “mental illness” was locatable in the brain rather than throughout the body.

The outrage and contempt that fuelled my informants’ critiques of CAMH’s awareness campaign hint at a deeper problem in the national conversation about “mental health,” namely the widespread assumption that it is principally non-psychiatrized people who view psychiatry with skepticism. I, too, have been a purveyor of this myth. I did not embark upon this project with the aim or expectation of collecting stories about people’s appalling experiences on psychoactive chemicals. While my original research objective was to investigate people’s rationales for resisting psychoscientific expertise, my original hypotheses were remarkably naïve: four years ago, I had scant knowledge of North American anti-psychiatry’s long and layered history, and I had envisaged interviewing undiagnosed individuals whose antipathy toward “treatment” arose more from secondhand fears of what might happen to them than from firsthand awareness of what did happen to them. Fieldwork was a sobering experience; despite their many political differences, the majority of my informants spoke either of chance encounters with psychiatry that led swiftly to forcible medication, or of initial optimism giving way to outrage at drugs’ adverse effects and doctors’ disinclination to listen. While the stories presented in this dissertation may not reflect those of all psychiatristized people, I would argue that they collectively signify an important corrective to the teleological narrative of upward, onward scientific progress—more humane treatments, more specific biomarkers—that institutional psychiatry has vaunted since the release of DSM-III in 1980. Whether participants had been hospitalized in the 1980s or the 2000s, whether they had been medicated in the 1970s or the 1990s, their accounts of rage and indignity—at being disbelieved by physicians, suffocated and usurped by chemicals, and treated with suspicion by family members—were strikingly similar. Knowing full well the epistemological and ideological authority that psychiatry enjoys in our society, it is little wonder that psychiatric survivors feel they must create their own “safe spaces” in which to share opinions and reconfigure concepts in ways that non-survivors might find alarming. To someone like Olivia, Cassidy, or Magda, the notion that “compliance” leads to
“health” is irreconcilable with what experience has taught them. To someone like MacDaniel, “insight” and “recovery” can only ever stem from a defiant anger toward unwanted interventions, not a deferential acceptance of them. To those of us who have never had biopsychiatric technologies imposed upon us against our will, and who are socialized into equating “madness” with danger, such conceptual reversals may feel vaguely troubling. Aren’t many psychiatrized people grateful for medication and treatment?

The answer is of course yes. But it is a “yes” that is pronounced so loudly and vociferously throughout the mass media that it threatens to drown out the dissenting voices of numberless others. What of all those who fall anywhere on the spectrum between ambivalent and scornful? What of Deirdre, whose voluntary usage of inpatient services did not prevent her from resenting her clinicians’ condescending attitudes and coercive insistence on drugs; or Richter, who described his antipsychotics as “poisons” that “stole years of my life” and attributed his recovery to political activism and affordable housing; or Melinda, taught by her one encounter with a mental health nurse that her flourishing imaginary worlds made her a target for unwanted psychiatrization? What of Ryan, who disdained psychiatry so much that he could not even bring himself to utter his diagnosis or discuss his hospitalization? What of Vanessa, who lost over two decades’ worth of memories to electroconvulsive currents? As shown earlier in this thesis, up to 73% of news articles about “mental illness” available to Canadian audiences over five years excluded the voices and viewpoints of the “mentally ill” altogether. Only 4% of these articles excluded the views of the non-“mentally ill” altogether, and another 3% gave priority to the views of the “mentally ill” while still including counterpoints from psychiatrists, psychologists, family members, neighbours, social workers, teachers, legislators, and law enforcement personnel. The large-scale erasure of psychiatrized voices from the cultural mainstream, not to mention the doubt that is systematically cast on these voices’ knowledge claims, has meant that experiences like my informants’ have come to be seen as anomalous—unbelievable and literally incredible—in spite of the frequency with which they occur. Lacking easy access to the mainstream media, psychiatric survivor activists like Judi Chamberlin, Lenny Lapon, Irit Shimrat, and Don Weitz have felt compelled to destabilize the official record by any means possible. As Chamberlin (1983: 18) once put it in Phoenix Rising,

We don’t go to demonstrate at the APA (American Psychiatric Association) because we suddenly think they’re going to get together and say, ‘Hey, you folks are right. We’re going to disband and stop being psychiatrists.’ … We know that’s not going to happen. We go there because we want them to know about our Movement, about our anger, so that even though they might not agree with it—they might pooh-pooh it, they might discount it—they can’t say that they didn’t know. They can’t say, ‘Oh, we thought all our
patients were grateful and happy,’ because they hear us out there yelling and screaming and telling them that we’re angry.

Out of the vital necessity to ensure that “they can’t say that they didn’t know” has arisen a rich efflorescence of anti-psychiatric critiques: in the Fish Manifesto, in the erstwhile anti-psychiatric press, at the annual “conferences on human rights and psychiatric oppression,” in medical consumerist organizations, in the Mad Pride movement, in orthomolecular theories, and in the small groups of individuals such as Acceptance, Folie à Deux, and Unhinged, whose words and deeds sustain, adapt, extend, curtail, combine, and contest these and other cultural fields. And yet, despite the prolific resistance initiatives, it remains remarkably easy for clinicians to plead ignorance—to insist that they truly “didn’t know”—in part because of totalizing constructs like “poor insight” and “mental illness,” which strip credibility from patients’ mouths before words are even spoken; and in part because, once freed of chemical straitjackets, many patients fear the potential consequences of announcing to their doctors that they have discontinued their “meds” and are better off for it. Angry and alienated, yet ever attuned to the possibility of forcible detention, these patients feel they have no choice but to disengage in secret, leaving intact the myth of incurability.

Psychiatrization and survival are not events with tidy beginnings and endings; psychiatrists are not the only ones who stigmatize and isolate, and psychiatry is but one of many forms of indignity that people survive. What of Sylvie, who left Acceptance in disgust after finding its members’ assumptions about mental patients intolerable; or Malcolm and Alé, who both left activism altogether in the 1980s due to burnout; or Sheila, who was denied a vote in the survivor advocacy group she had joined in the 1990s because she had never been hospitalized? What of Yashar, whose psychiatrized and racialized selves were pitted against each other during his confrontation with Ryan; or Ivy, whose estrangement from Unhinged went virtually unremarked by the people she had so eagerly fed and chauffeured? In political activist circles, infighting and backbiting can at times be unavoidable due to participants’ heterogeneous backgrounds, values, motives, aims and aspirations. In anti-psychiatric circles, such conflicts peel away the façade of ideological unity that many members feel obliged to maintain whilst fighting what Olivia called “the real enemy,” offering additional hints of what can happen when “compliance”—deference to a prescribed truth regime—becomes an end that justifies any means.

My analysis of ideological and interrelational frictions in anti-psychiatry communities is by no means complete, and my conclusions are far from exhaustive. In documenting Unhinged’s final months and considering the imbrications of race, gender, and class that marked its
disintegration, I have sought both to unsettle the solidaristic fables that are foundational to much political activism and to flag an avenue for future inquiry. As countless racialized feminists can affirm, the social dynamics that facilitate the rise of some activists (often white and male) into respected leadership positions are precisely those that press others (often non-white and non-male) into permanent supporting roles. Given that anthropologists involved with movements like Occupy Wall Street have made similar observations (see Liu 2012), it would seem there is a pressing need for continued investigations into how, why and when painful and alienating norms are reproduced, rationalized and even vigorously defended in progressive political groupings, as well as how such norms can be fortified by highly psychiatrized allegations of irrationality, hypersensitivity, paranoia, and “craziness.”

While writing this conclusion and hearing out my former informants’ views on the CAMH advertising campaign, I learned that the pharmaceutical multinational GlaxoSmithKline had pled guilty earlier this summer to illegally promoting Paxil, its best-selling SSRI, to children and teenagers; illegally promoting Wellbutrin, another antidepressant, for unapproved indications; misrepresenting clinical trial data; and using kickbacks to motivate doctors to prescribe its brands. As reported by the New York Times and Toronto Star, the company was ordered by the United States government to pay a fine of $1 billion in criminal damages and $2 billion in civil damages (Thomas and Schmidt 2012, Hsu 2012). Given that GlaxoSmithKline’s (2011: 136) most recent shareholder report announced over £27 billion or approximately $43 billion USD in total sales for the previous fiscal year, the $3 billion fine—reportedly the largest health fraud settlement in history—can easily be rationalized as just one of many necessary sacrifices on the road to increased profits and enhanced market share. When I think of people like Helen and Armaghan, whose love for their children led them to place all their hopes in modern pharmacology, I am reminded of the breathtaking extent to which our conceptual frames are shaped by industries whose priorities are widely accepted as normal. It is a crime to offer kickbacks, but it is not a crime to market diseases on television airwaves or to invite viewers to request specific drugs from their doctors. It is the legal prerogative of pharmaceutical firms to persuade people that they and their loved ones are “crazy” if doing so will help maximize profits for shareholders. It is normal for the mainstream media to denounce particular cases of corporate avarice while celebrating free market ideologies on most other weekdays. It is normal for policymakers and newsmakers to affirm the legal right of medical “consumers” to accessible and affordable medication, while saying nothing of their right to accessible and affordable information—about their treatments and about their world.
By fleshing out the biographical contexts of my informants’ psychiatrization experiences and mapping the cultural and economic terrain in which their resistance is rooted, this dissertation encourages a rethinking of what is considered normal—for institutions, investors, and media outlets no less than for individuals—and contributes to a growing body of ethnographic literature on the ways in which psychiatric theory “seeps into popular culture like the dye from a red shirt in hot water” (Luhrmann 2001: 20). As many social scientists have elegantly shown, the pathologization of undesirable minds and bodies cannot occur in clinics without first occurring in homes, workplaces, classrooms, courtrooms and newsrooms. As postcolonial scholars and critical race theorists have shown, the psychometric and physiognomic assessment tools that modern psychiatry has inherited are rooted in the hierarchies of knowledge that made Western medicine integral to colonial ruling regimes. So long as our society continues to view “mental illness” through the lens of individual pathology—as something separable from the tiny, cumulative humiliations that trickle out from historical and systemic injustices in which we are all complicit—the reasons why some people happen to go insane, or succumb to pain, will continue to mystify. Yet it is not so mysterious that some of us end up descending into madness in a world where, “if we find the going difficult and want to disengage, we are prescribed an emotional painkiller and advised to carry on regardless” (Corry 2006, quoted in Maddock and Maddock 2006: 132). As anthropologists must continue to argue, it is neither sick nor weak to crumble when the weight of the world is pressing irresistibly on one’s shoulders; and it is neither irrational nor immoral to reject pills and labels if, as in so many cases, their benefits do not outweigh their costs.
Appendix I. Map of Municipalities in the Greater Toronto Area (GTA)

The original version of this map was created in 2006 by user “Mortadelo2005” for the Wikimedia Commons database, and is available at http://en.wikipedia.org/wiki/File:Greater_toronto_area_map.svg (accessed 12 August 2012). My adaptation of it follows the provisions of its Creative Commons Attribution 2.5 Generic (CC BY 2.5) license under which third parties are free to share, copy, distribute, transmit, remix, and adapt the licensed work on the sole condition that its author/licensor be acknowledged in a manner that does not suggest his/her endorsement. This image’s full license terms are accessible at http://creativecommons.org/licenses/by/2.5/deed.en. I gratefully acknowledge Mortadelo2005’s work and rights. Aside from this map, no other part of this dissertation is published under the CC BY 2.5 license, i.e. no other part of this dissertation may be copied, distributed, transmitted, remixed, or adapted for use in the manner described on this page.
Appendix II. Archival Images and Illustrations

Figure 3.1 “Tone-Deaf to the Screams / Of the Instruments / Upon Which They Play.” At left, an article in the Madness Network News on the overturning of a ban on electroshock in Berkeley, California, which had originally been instituted on the basis of a citywide referendum (winter 1983/84, vol. 7, no. 3, p. 1, photograph © Carolyn Wendt). At right, from the same issue (p. 16), a poem about the disparity between psychiatrists’ intentions and their patients’ experiences (© Susan Packie, adjacent illustration © Ellen Frye).

Figure 3.2 “All the Fits that’s News to Print.” The front pages of four issues of the Madness Network News (spring 1978, vol. 4, no. 6; winter 1979, vol. 5, no. 3; winter 1981/82, vol. 6, no. 4; and winter 1983/1984, vol. 7, no. 3). Illustrations from left to right: a cartoon depicting a crowd of demonstrators storming a castle defended by syringe- and pill-wielding psychiatrists (© J. Beller), a march in the Hague against a Dutch commitment law (© unnamed photographer), a drawing of a patient being subjected to forced treatment (© Gerrine), and a cartoon of a homeless man browsing through garbage cans (© unknown artist for People’s World, a communist newspaper).

141 Scans and screen captures produced by the author. Images are presented in a low resolution that impairs legibility so as not to compete with the potential commercial interest of copyright holders. The original, scanned materials are the copyright of their respective creators, and are discussed in chapters 3, 4, 6, and 8 under the provisions of section 29 of the Copyright Act of Canada (“Fair dealing for the purpose of research… criticism or review,” Department of Justice, Canada, 2005 [1985]: para. 1-2). Despite reasonable efforts, most contributors to the Madness Network News are now untraceable due to the passage of time, the intervention of death, the absence of any successor organizations to the newspaper’s editorial collective, and authors’ routine usage of mononyms, initialisms, and pseudonyms. Images from Phoenix Rising are courtesy of the Psychiatric Survivor Archives of Toronto, which has made all back issues publicly available in their entireties at www.psychiatricsurvivorarchives.com/phoenix.html.
Figure 3.3 “Legislation & Litigation.” Madness Network News’s regular feature on court rulings, legal battles, and class action lawsuits of potential interest to psychiatric inmates and anti-psychiatry activists. The above example is from the winter 1979 issue (vol. 5, no. 3, pp. 18-19, © unspecified members of the Madness Network News Collective).

Figure 3.4 “You Deprive Us of Love and Give Us Candy and Bingo.” At left, the front cover of the Madness Network News Reader (1974, Glide Publications; designed by Jon Goodchild and © Madness Network News). At right, a poetic declaration originally published in an early issue of MNN (© Cyril Athana Kolocotronis).
Figure 3.5 “Mad Librarian.” Madness Network News’s regular annotated listing of books and publications of potential interest to anti-psychiatry organizers, as vetted by a collective of psychiatric ex-inmates. The above example is from the spring 1978 issue (vol. 4, no. 6, p. 18) and includes an entry for Elizabeth Packard’s memoirs. Text and design © unspecified members of the Network Against Psychiatric Assault, San Francisco.

Figure 3.6 Rising From the Ashes. The covers of the first four issues of Canadian anti-psychiatry magazine Phoenix Rising (spring 1980, vol. 1, no. 1, the official inaugural issue; summer 1980, vol. 1, no. 2, a theme issue on prison psychiatry; fall 1980, a theme issue on electroconvulsive therapy; and winter 1981, vol. 1, no. 4, a theme issue on the psychiatrization of women). The phoenix design is © an unnamed artist; the prison photograph is © Arnold Bruner; the electroshock photograph is from a book called The History of Shock Therapy; and the cartoon is from the feminist humour anthology Pulling Our Own Strings.
Figure 3.7 “Phoenix Pharmacy.” Three examples of Phoenix Rising’s regular feature on the adverse effects of common psychiatric drugs (from spring 1983, vol. 3, no. 4, p. 34; June 1987, vol. 6, no. 4, p. 29; and July 1990, vol. 8, no. 3/4, p. 19). The second one critiques an ad for an antidepressant that originally appeared in the June 1986 Canadian Journal of Psychiatry. The ad is © Bristol Laboratories.

Figure 3.8 “Giving Them the Bird.” A regular Phoenix feature recognizing individuals with either a “Phoenix Pheather” or a “Turkey Tail,” the former for having “made a courageous and significant contribution to bettering the lot of psychiatric patients,” the latter for having “shown outstanding lack of understanding of the position of psychiatric inmates, or... contributed to making their situation worse” (Phoenix Rising Editorial Collective 1980c: 4). This example is from Phoenix Rising vol. 2, no. 1 (spring 1981, p. 6). Artwork © unnamed artist.

Figure 3.9 Vegetables. One of the many editorial cartoons published in the anti-psychiatric press. This one appeared in both Phoenix Rising (vol. 4, no. 2, fall 1983, p. 12) and Madness Network News (vol. 7, no. 5, winter 1985, p. 1). © an artist identified only as “cps.”
Recovering from psychiatry: How I got myself back

by Jean Shov

The first page of a text about a personal story. The author describes her experiences in psychiatric institutions and the challenges she faced in recovering from them. She mentions the importance of self-empowerment and the need for support and understanding from others.

Figure 3.11  “Sane Response to an Insane World.” At left, the cover to Phoenix Rising vol. 3, no. 2 (November 1982, photograph © Phillip Hoffman), a theme issue on the link between housing and “mental health.” At right, the editorial from Phoenix Rising vol. 3, no. 3 (winter 1983, p. 2, artwork © unnamed artist), which argued that going mad with “rage, confusion, hopelessness and fear” was a “necessary survival instinct” in an unjust society.

Figure 3.13 Madness Network News’s Coverage of the 1982 Toronto Conference. Attendees of the 10th Annual Conference on Human Rights and Psychiatric Oppression stage a sit-in at the Toronto Sheraton, the venue of the 135th meeting of the APA, and are confronted by police (Madness Network News, fall/winter 1982, vol. 6, no. 6, p. 1 and front cover). Photographs © John Wood.
Figure 3.14 “Declaration of Principles.” At left, a scene from a piece of guerrilla theatre that was performed during the May 1982 clash of conferences (Phoenix Rising vol. 3, no. 1; photograph © Connie Neil). At right, a set of principles ratified by the anti-psychiatry conferees (Phoenix Rising vol. 3, no. 2, p. 40, November 1982).

Figure 3.15 “We’ve Always Been Thrown a Few Crumbs Along With Our Thorazine.” Lenny Lapon’s essay on the co-optation of prominent anti-psychiatry activists by NIMH and other mental health organizations (Madness Network News, winter 1985, vol. 7, no. 5, p. 6). Artwork © unnamed artists.
Figure 3.16 “We Believe that Psychiatry Cannot Be Reformed but Must be Abolished.” At left, the front page of the final Madness Network News issue (vol. 8, no. 3, summer 1986, photograph © Anne Boldt). At right, a position paper that the MNN Collective had drafted for this issue prior to dissolving; the paper’s first sentence is this figure’s caption. The cartoon is © Post Amerikan, an Illinois alternative newspaper.

Figure 3.17 “Farewell.” At left, the cover of Phoenix’s final issue, a theme issue on the psychiatrization of gays and lesbians (vol. 8, no. 3/4, July 1990, cover photograph © Konnie Reich). At right, the editorial for this issue, which disclosed the magazine’s 1988 eviction by its original publisher, On Our Own.
**Figure 4.3** “Researchers’ Guess.” At right, a screen capture of a *Toronto Star* article (23 July 2010) about a study published in the journal *Biological Psychiatry*. The study contends that depressed people have difficulty distinguishing colour gradations. A line referring to the accompanying photograph reads, “It is difficult to say what the depressed person sees, but researchers’ guess is that it is similar to seeing a picture in which the contrast has been reduced.” Text and design © *Toronto Star*.

**Figure 4.4** “There’s a Really Fundamental Difference in the Way They’re Perceiving Things.” Above left, a news article about a study published in the *Journal of Neuroscience* (*Toronto Star*, 4 December 2009, p. L4). The article states nine separate times that depressed people see the borders of objects “differently.” However, the nature of this “difference” is never specified, so the accompanying photograph serves no purpose. In association with the topic of the article, the photo’s caption (“The brain recognizes ‘apple’ by the shape created by its edges”) implies that depressed people would have difficulty processing this image, but this is a conclusion that readers are left to reach on their own. Text and layout © *Toronto Star*. Photograph © Shutterstock.

**Figure 4.5** “Illness Kills, Not Individual.” At left, a news article in which “[e]xperts help explain what may drive parents to take children’s lives” (*Toronto Star*, 11 January 2009, p. A7). The accompanying photograph depicts the funeral of three children who were murdered in 2008 as part of a parental suicide pact. The only quoted experts are a psychologist and two psychiatrists, one of whom supplies the article’s closing line: “‘We have to move away from this idea that the parent killed the child,’ she says, ‘because it’s the illness that kills, not the individual’” (Dominique Bourget, quoted in para. 25). Text and layout © *Toronto Star*. Photograph © Karl Tremblay/The Canadian Press.
Figure 6.1 “Come Back Here! You Can’t Fly. You’re Just a Caterpillar!” A cartoon published on the front cover of *Phoenix Rising* vol. 3, no. 4 (spring 1983). A woman and a man with a large butterfly net yell and gesture into the distance. The target of their admonishment/astonishment does not appear on-panel: the “caterpillar” who is supposed to be unable to fly is long gone. © Uncredited artist.

Figure 6.2 “Common Myths.” Both sides of a pamphlet published by the NGO MindFreedom International (MFI) and distributed in downtown Toronto by psychiatric survivor activists in spring 2010. Its interior panels display a chart that challenges popular beliefs about the biological permanence of mental illness. MFI invites supporters to download this pamphlet at www.mindfreedom.org/brochure and leave copies “in libraries, community centers and hospitals” (MindFreedom International 2009/2010: 15). Text and design © MindFreedom International.
Figure 6.3  The Enemy? The first page of a magazine article that caught the attention of an informant during his search for possible causes for his son’s sullen behaviour (Moods, spring 2009, vol. No., pp. 17-18). The article urges concerned family members to be alert to signs of mental illness and to intervene when sufferers reject offers of help due to their “poor insight” (p. 17). The illustration portrays a limbed brain menacing a seated woman. Text, image, and design © author Wendy Campbell, artist Nicole DeCaria, and Moods magazine.

Figure 6.4  “Look At This Stuff, Look.” Some interior pages from Depression Expression, a single-issue newspaper published by the Toronto environmentalist group Greenspiration and distributed among downtown psychiatric survivors (originally published in 2006 and annually reissued in the same format thereafter). © Greenspiration.
Figure 7.1 “Next Month in Toronto, He’s Scheduled to Talk.” A newspaper column describing the mandate of the then-upcoming PsychOut conference (Toronto Star, 17 April 2010, p. L6). The opening paragraphs describe David Carmichael’s crime, summarize his subsequent interactions with the legal system, and announce that he is slated to speak at the conference. The accompanying photograph depicts Carmichael standing in a field beneath a dark cloudscape; its caption reiterates that Carmichael is on the conference’s schedule. Text and design © Toronto Star, photographer Dave Chan, and columnist Helen Henderson.

Figure 8.1 “Maybe It’s A Hospital.” Two of the advertisements that the Centre for Addiction and Mental Health (CAMH) released in the summer of 2012 as part of a campaign to raise awareness about mental illness. These ads appeared in subway stations, vehicles, and bus shelters throughout the Toronto transit system, as well as in major metropolitan newspapers. This campaign earned an Honourable Mention in the Public Service and Advocacy category of the 2012 Extra Awards for excellence in advertising (Newspapers Canada 2012). Images © CAMH. Designed by the DentsuBos agency.
Appendix III. Annotated Glossary of Abbreviations

**APA**  
*American Psychiatric Association.* The main professional organization for psychiatrists and psychiatric trainees in the United States, and the largest psychiatric organization in the world. Like the American Anthropological Association, the APA’s nominally regional status belies its enormous international influence on disciplinary norms and standards. The APA publishes the DSM, whose codes are used worldwide (although not in unvarying ways; see Lakoff 2005). In 2003, a group of psychiatric survivors held a hunger strike to compel the APA to produce evidence for a baseline standard of neurochemical “normalcy” against which chemical imbalances can be identified and pharmacologically corrected. Three weeks into the strike, the APA issued a statement conceding that no “reliable or predictive bio-markers” currently exist for specific mental disorders “or mental disorders as a group” (quoted in Coleman 2008: 343).

**CAMH**  
*Centre for Addiction and Mental Health.* Canada’s largest mental health and addictions teaching hospital, in which both clinical research and inpatient/outpatient treatment are undertaken. Affiliated with the University of Toronto, its main facilities are located in the City of Toronto. CAMH was formed in 1998 from a merging of four pre-existing institutions: the Donwood Institute, the Clarke Institute of Psychiatry, the Addiction Research Foundation, and the Queen Street Mental Health Centre (formerly the Toronto Hospital for the Insane; see Reaume 2009).

**CBC**  
*Canadian Broadcasting Corporation.* Canada’s national public television and radio broadcaster, owned by the federal government and headquartered in Ottawa. Unlike its British counterpart (BBC), “a considerable portion” of CBC’s programming budget derives from commercial advertising revenues (CBC/Radio-Canada 2009: para. 5). Unlike its American counterpart (PBS), CBC is not permitted to raise funds from individual donors. Despite competition from private broadcast networks, CBC.ca remains one of the nation’s most frequently visited English-language news websites (CBC/Radio-Canada 2009: para. 27).

**CNA**  
*Canadian Newspaper Association.* A non-profit trade association and lobbying group that represented over a hundred Canadian daily newspapers from June 1996 through January 2011. Its mission was to “promote the positive reputation of newspapers as an essential medium that benefits all Canadians, and as an effective vehicle for advertisers” (Newspapers Canada 2010b: para. 1). In January 2011, the CNA merged with the Canadian Community Newspapers Association to become “Newspapers Canada.” CNA continues to be represented by a separate board of directors within Newspapers Canada.
**C/S/X**  **Consumer/Survivor/Ex-Patient.** An umbrella term that is meant to include anyone who has ever been in the psychiatric system, whether as an inpatient or as an outpatient. The use of this term is controversial within psychiatric survivor communities, as it lumps together individuals who feel that psychiatry has helped them and individuals who feel that psychiatry has harmed them, as well as everyone in between.

**CTV**  By convention, **Canadian Television**, although virtually never referenced in its non-acronymic form. CTV is Canada’s largest privately owned broadcast network. During the timeframe in which I collected news items for analysis (chapter 4), CTV was owned by the Woodbridge Company, which was and continues to be the controlling shareholder of the *Globe and Mail* and the Thomson Reuters newswire service. CTV was acquired by Bell Media for $3.2 billion in April 2011. CTV produces the *W-FIVE* current affairs television series, which featured David Carmichael’s story in April 2007 (chapter 7).

**DSM**  **Diagnostic and Statistical Manual of Mental Disorders.** Published by the APA and currently in its fourth revised edition (DSM-IV-TR). The fifth edition (DSM-5, previously known as DSM-V) is scheduled for release in 2013. The DSM is currently the definitive diagnostic guidebook among psychiatrists and clinical psychologists around the world. Since the publication of DSM-III in 1980, the manual’s codes have been widely adopted in reimbursement systems, pharmaceutical product development programs, hospital records, medical curricula, legal cases, and public health initiatives, thereby solidifying psychiatry’s cultural authority and medical prestige. Editions of the DSM prior to DSM-III were incomparably less influential, even ridiculed, for reasons documented in chapter 3 (see also Lakoff 2005, Luhrmann 2001, Whooley 2010). See also APA and FDA.

**ECT**  **Electroconvulsive Therapy.** A procedure involving the electrical inducement of tonic-clonic seizures. Known as “electroshock” or “shock” among psychiatric survivors, and invented in the early twentieth century during an era when psychiatrists openly equated cure with docility (“these people have for the time being at any rate more intelligence than they can handle and… the reduction of intelligence is an important factor in the curative process,” Myerson 1942, quoted in Andre 2009: 50). Although ECT can sometimes alleviate depressive symptoms, many recipients experience irreversible memory loss and diminished cognitive ability (Andre 2009, Breggin 2008, Burstow 2006a and 2006b, Sackheim et al. 2007; see also Vanessa’s story in chapter 5). Debates around ECT thus tend to focus on the problem of inadequate informed consent and the question of whether the treatment’s potential benefits warrant its costs.

**FDA**  **Food and Drug Administration.** An agency of the United States Department of Health and Human Services, and the regulatory body that oversees the safety and availability of
foods, dietary, supplements, and medications, as well as other biopharmaceuticals such as vaccines and blood products. In 1962, the FDA introduced new regulations that would eventually facilitate a nosological revolution in psychiatry—drug companies were now required to demonstrate that new compounds acted on specific diseases, instead of merely demonstrating that they were safe. The publication of a set of specific disease entities in 1980 (DSM-III) provided the drug companies with an elegant solution to the FDA’s requirements. As sociologist Andrew Scull (2010: 1247) observes, “soon enough the polarity would be reversed, and the creation of a new class of drugs would lead to the creation of a new psychiatric ‘disease’ to match” (see chapter 3).

GTA Greater Toronto Area. A metropolitan area in southern Ontario, consisting of the City of Toronto and four surrounding suburban municipalities: Halton Region, Peel Region, York Region, and Durham Region. Each of these regions, in turn, consists of several smaller municipalities and communities (see Appendix I for a map).

ICD International Classification of Diseases. A standard set of diagnostic codes that is used in epidemiological research, clinical practice, reimbursement systems, morbidity and mortality reportage and public health planning. The ICD is published by the WHO and is periodically revised. Its current edition, ICD-10 (released in 1994), incorporated several classificatory innovations from the DSM-III. However, the correspondence between the ICD’s nomenclatures and the DSM’s is not always exact.

IOC Involuntary Outpatient Committal/Commitment. A type of legal mechanism that was introduced in many Western nations following the deinstitutionalization of mental healthcare in the 1980s. IOCs require psychiatric outpatients to take medication or face forcible detention. Psychiatric survivors have objected to IOC laws on several grounds: they unjustly and inaccurately assume that psychiatrized people are prone to violence; they oblige outpatients to ingest chemicals that cause them ill effects; and they disproportionately target the poor. In the province of Ontario, involuntary outpatient committals are called Community Treatment Orders (see Fabris 2011).

Kirby Report Nickname for a senatorial committee report entitled Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, which was authored by the Standing Senate Committee on Social Affairs, Science and Technology and chaired by the then Honourable Michael J.L. Kirby. This report described Canada’s first nationwide study of existing mental health and addiction services, and was based on the input of three hundred “stakeholders” who attended public hearings between 2002 and 2005, as well as electronically submitted feedback. The Kirby Report found that Canadian mental healthcare systems was in need of wide-ranging
reform. Among its chief rationales was the assertion that “mentally ill” workers represent an enormous drain on the national economy (chapter 4). See also SSC.

**LGBTQ**

**Lesbian, Gay, Bisexual, Trans, Queer/Questioning.** An umbrella term that began to be used in the 1990s in order to reflect the wide variety of constituencies within what had previously been known as the “gay community.” Variants of this acronym sometimes include additional letters (e.g. I for “intersex,” C for “curious,” P for “pansexual,” A for “asexual”). The usage of this umbrella term is not uncontroversial, due to its implicit conflation of gender identity and sexual orientation as well as its assumption of monolithic political solidarity within constituent communities, among other reasons.

**MFI**

**MindFreedom International.** An international organization of psychiatric survivors and activists who seek “to win human rights and alternatives for people labeled with psychiatric disabilities” (MindFreedom International N.d.a: para. 1). Branches of MFI exist in multiple countries, and the organization is recognized by the United Nations’ Department of Economic and Social Affairs as a human rights NGO that enjoys roster consultative status. Many MFI publications challenge the claim that psychiatrized individuals suffer from immutable and congenital biological abnormalities (chapter 6).

**MHCC**

**Mental Health Commission of Canada.** Formed by the Federal Government of Canada in March 2007 following the release of the senatorial committee report *Out of the Shadows at Last*. Tasked with facilitating the creation of a nationally integrated mental health system and assigned a ten-year mandate of four main initiatives: devising a national “mental health strategy,” “working to reduce stigma,” “advancing knowledge exchange,” and researching homelessness (Mental Health Commission of Canada N.d.: para. 3; see also White 2009). The MHCC is funded by Health Canada. Its first and current chair is former senator Michael Kirby. See also Kirby Report and SSC.

**MNN**

**Madness Network News.** An American anti-psychiatry newspaper, published from 1972 through 1986, and based in the San Francisco Bay Area. Arguably the most influential journal in the anti-psychiatry/psychiatric inmates liberation movement during the 1970s and 1980s. At its peak, *MNN* had readers in the United States, Canada, and Europe, and served as a unifying institution for anti-psychiatry activists throughout the West. The *MNN* editorial collective eventually disintegrated due to irresolvable ideological conflicts and financial hardship (chapter 3).

**MPU**

**Mental Patients Union.** One of the first collectives of former psychiatric patients. Founded in 1971 and based in the United Kingdom, the MPU authored the famous “Fish Manifesto,” whose Marxist agenda and iconography became popular in some North American iterations of anti-psychiatry. Like its North American counterparts, the MPU restricted membership to individuals with firsthand experiences within psychiatric
systems. The MPU’s main successor organization was the Campaign Against Psychiatric Oppression, which distanced itself from the Fish Manifesto in the 1980s.

**NADbank**

**National Audience Databank Inc.** A research organization composed of three groups of stakeholders: Canadian daily newspapers, media-buying companies, and advertisers. As “the principal research arm of the Canadian daily newspaper industry,” NADbank “conducts research in Canadian urban markets to provide cost-effective and accurate in-depth marketing information for its members to assist in the buying and selling of daily newspaper advertising in Canada” (National Audience Databank 2011: 4).

**NAMI**

**National Alliance on Mental Illness.** A prominent American advocacy group that represents the families of psychotratized people. Founded in 1979, NAMI regularly launches anti-stigma campaigns and lobbies for looser restrictions on prescribing practices. In 2009, the *New York Times* reported that a majority of donations made to NAMI came from pharmaceutical companies; most egregiously, 75% of the donations that NAMI received from 2006 to 2008 came from pharmaceutical companies (Harris 2009). In response to this report, NAMI now discloses all donations larger than $5,000. During the first and second quarters of the 2012 fiscal year, 50% of these donations came from either drug manufacturers (46%) or drug retailers, drug insurers, compliance enforcement firms and private hospitals (4%). (See National Alliance on Mental Illness 2012a and 2012b for exact monetary figures and company names; see Morrison 2005 for a useful summary of psychiatric survivors’ critiques of NAMI’s aims and tactics.)

**NAPA**

**Network Against Psychiatric Assault.** One of the first North American collectives of former psychiatric patients whose founding agenda included the goal of abolishing psychiatric systems and institutions. Founded in 1972 in San Francisco, California.

**NIMH**

**National Institute of Mental Health.** One of the twenty-seven institutes in the National Institutes of Health (NIH), which is an agency of the United States Department of Health and Human Services. According to its strategic plan, NIMH “envisions a world in which mental illnesses are prevented and cured” (2008: para. 1). To this end, two of its key objectives are to “Promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders” and to “Chart mental illness trajectories to determine when, where, and how to intervene” (National Institute of Mental Health 2008: para. 5-6). Its research agenda focuses chiefly on biological problems and pharmacological solutions. Psychiatric survivors who do not see their existential anguish/unruliness as “mental illness”—and who may not wish to be “cured”—tend to view the NIMH’s influence with fear and outrage. In the 1980s, some survivors who took jobs linked to NIMH programs were accused by their peers of having been “co-opted” by mental health money (see chapter 3).
OCAP  

**Ontario Coalition Against Poverty.** A grassroots anti-poverty organization, founded in the 1980s and integrally involved in numerous direct action campaigns in and around the Greater Toronto Area (e.g. rallies, blockades, and marches, typically in response to budget cuts, potential or actual legal changes that discriminate against the poor and homeless, and/or other curtailments of social services). OCAP receives funding from individual donors and some labour unions.

ODSP  

**Ontario Disability Support Program.** An income support program administered by the provincial Ministry of Community and Social Services, which is available to adult residents of Ontario with a qualifying mental or physical disability, as defined in the Ontario Disability Support Program Act. The monthly financial supplement that is available to an eligible applicant is dependent on his or her family size, income, assets, and housing costs (Ontario Ministry of Community and Social Services 2012: para. 3). ODSP also covers certain other healthcare expenses, such as dental services, diabetic supplies, and prescription drugs that are listed in the Ontario Drug Benefit formulary. One of my informants pointed out that ODSP reinforces a narrow conception of “mental health,” in that it covers psychiatric drugs but makes no provisions for other factors that are integral to recovery (e.g. access to education and information, participation in political discourse, meaningful involvement in a community, see chapters 6 and 7).

OHIP  

**Ontario Health Insurance Plan.** The governmental health insurance plan for Canadian citizens, permanent residents, and work visa holders whose primary and permanent dwelling is in Ontario. Under the 1984 Canada Health Act, each Canadian province is obliged to run such a plan in order to receive federal transfer payments. OHIP is funded by provincial and federal tax revenues, and entitles eligible individuals to emergency and most preventive medical services free of charge—the fees for these services are billed through OHIP to the government. OHIP does not cover prescription drugs, dental services, or eye examinations for adults with no pre-existing ocular conditions. However, OHIP cardholders who spend more than 4% of their net annual household income on certain prescription drugs are eligible for a public drug insurance plan called the Trillium Drug Program. Individuals with certain disabilities are also eligible for assistance under ODSP. When a treatment or procedure is removed from the list of services covered by OHIP, it has been “delisted.” Thus, local anti-psychiatry activists routinely advocate the “delisting” of controversial procedures (see **ECT**) in the hopes that taxpayers will agree that it is inappropriate to publicly fund them.

OMHA  

**Ontario Mental Health Act.** The piece of provincial legislation that regulates admissions into psychiatric units, originally passed in 1990 and last amended in 2010. Under the OMHA, police officers have the discretionary authority to detain for
psychiatric evaluation anyone whom they believe to have engaged in disorderly and/or threatening behaviour, and to do so on the word of third parties. Under the OMHA, physicians also have the discretionary authority to change the status of voluntary patients to that of involuntary patients. While patients are entitled to refuse treatment, they lose this right if declared “incapable” by a psychiatrist. Patients committed for involuntary stays of over two weeks may appeal the decision to a Consent and Capacity Board, the minimal composition of which must include a lawyer, a psychiatrist, and a member of the community. Consent and Capacity Boards’ decisions may be appealed to the Ontario Superior Court of Justice. Since 2000, the OMHA also authorizes physicians to put psychiatric outpatients on Community Treatment Orders (see IOC).

PAIMI Protection and Advocacy Act for Individuals with Mental Illnesses. Passed by the United States Congress in 1986. PAIMI mandated the creation of advocacy councils in mental hospitals in all fifty states, and required that at least 60% of these councils’ members be former psychiatric patients or their family members (Rissmiller and Rissmiller 2006). Many psychiatric survivors objected to PAIMI’s implicit assumption that the interests of families and the interests of patients necessarily coincided.

PR, Phoenix Phoenix Rising. A Canadian anti-psychiatry magazine, published from 1980 to 1990, and based in Toronto. Editors and contributors included many prominent members of the local psychiatric survivor community, some of whom also wrote for Madness Network News. As one survivor who was politically active in the 1980s put it, “No one who lived that era forgets Phoenix Rising.” The magazine ultimately had to shut down due to a lack of funds. During its decade in print, Phoenix never solicited or accepted funds from “mental health” organizations.

PSAT Psychiatric Survivor Archives of Toronto. A grassroots organization whose formal mission is to preserve historical materials produced by and/or associated with individuals who have experienced the psychiatric system. PSAT was founded in 2001 and is staffed by volunteers who are also psychiatric survivors. Its holdings are not currently available to the public, as financial and logistical limitations have precluded its establishment of a reading room (accurate as of March 2013). Following an extensive fundraising campaign in 2010, PSAT sponsored the instalment of nine plaques around the boundary walls of CAMH’s Queen Street site to memorialize the unpaid labour of the psychiatric patients who built these walls in the 19th century.

Purple K Nickname for a chemical fire suppression agent, the principal ingredient of which is potassium bicarbonate. One of my informants compared the effects of the psychotherapeutic drugs he was forced to ingest during a hospitalization to the potent extinguishing effects of this agent (“It suffocates the fire inside,” see chapter 6).
**Shrink**  Disparaging slang term for psychiatrist, frequently used by psychiatric survivors and their allies, e.g. in the title of Shrink Resistant, a landmark book in the Canadian anti-psychiatry movement (Burstow and Weitz 1988). The origins of this colloquialism are obscure. Some of my informants have hypothesized that it is a truncated form of the word “headshrinking” and is meant to compare psychiatry with Amazonian tribes once known to sever, shrink, and display the heads of enemies.

**SNRI**  Serotonin-Norepinephrine Reuptake Inhibitor. A class of antidepressant. SNRIs increase the presence of two neurotransmitters (serotonin and norepinephrine) in a user’s synapses by preventing their uptake into other neurons through cell membranes. Neurons are the cells of the nervous system, including the brain. A synapse is the space between a neuron and another cell, whether neural or non-neural. Neurotransmitters are chemicals that transmit information from neurons to other cells by moving across synapses.

**SSC**  Standing Senate Committee on Social Affairs, Science and Technology. A permanent committee of the Senate of Canada, consisting of fourteen senators and tasked with investigating issues and evaluating spending proposals related to its assigned area of public policy. In May 2006, this SSC released an influential report entitled Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada, which argued that “mentally ill” workers represent an enormous drain on the national economy and that “undetected” mental illnesses are a major source of non-productivity in the workplace (chapter 4). See also Kirby Report.

**SSRI**  Selective Serotonin Reuptake Inhibitor. A class of antidepressant. SSRIs increase the presence of serotonin in a user’s synapses, by preventing its uptake into other neurons through cell membranes (see “SNRI” for anatomical definitions). Although not all users complain of adverse effects, SSRI usage has been associated with a wide range of untoward somatic and psychological symptoms, including suicidality and physical dependence. Abrupt discontinuation has been linked to tragic outcomes. See chapters 5 through 7 for ethnographic context.

**WHO**  World Health Organization. The “directing and coordinating authority for health within the United Nations system” (World Health Organization 2012a: para. 1). Its responsibilities include the articulation of practical norms, ethical standards, and policy options across international settings, the provision of technical support and advice, and the assessment of global trends in health and healthcare (World Health Organization 2012b). The WHO is the publisher of the ICD, as well as the World Health Report, an influential annual publication, each of whose issues addresses a specific global health issue. The theme of the 2001 World Health Report was “mental health.”
Works Cited

Ackerknecht, Erwin H.

Adler, Patricia A., and Peter Adler

Agriculture and Agri-Food Canada

Aia, Pratibha G. with Gonzalo J. Revuelta, Leslie J. Cloud, and Stewart A. Factor

Ainslie, Donald C.

Allan, Clare

Allday, Kathy

Amador, Xavier F., and Anthony S. David (eds.)


American Psychiatric Association

Anderson, Elijah

Anderson, Warwick

Anderson, Warwick, with Deborah Jenson, and Richard C. Keller

Anderssen, Erin

Andre, Linda
Andrews, Jonathan, with Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington

Anthony, William A.

Appelbaum, Kalman

Appelbaum, P.S.

Armstrong, Pat

Arnett, Jeffrey Jensen

Arney, Jennifer, and Adam Rafalovich

Ashmore, Malcolm, with Katie MacMillan, and Steven D. Brown

Atkinson, Joshua D.

Austin, John L.

Aviv, Rachel

Baer, Hans A., with John Hays, Nicole McClendon, Neil McGoldrick, and Raffela Vespucci

Baer, Hans. A, with Merrill Singer, and Ida Susser

Baigrie, Brian

Bailey, Olga Guedes, with Bart Cammaerts, and Nico Carpentier

Baker, C. Edwin.

Bamford, Sandra

Bangay, Frank
Barker, Joshua  

Barrett, Robert J.  

Basaglia, Franco  
1964  The Destruction of the Mental Hospital as a Place of Institutionalisation: Thoughts Caused By Personal Experience with the Open Door System and Part Time Service. First International Congress of Social Psychiatry. London, United Kingdom.  

Bauer, Martin W., with Kristine Petkova, Pepka Boyadjieva, and Galin Gornev  

Baughman, Fred, with Mary Boyle, Peter Breggin, David Cohen, Ty Colbert, Pat Deegan, Al Galves, Thomas Greening, David Jacobs, Jay Joseph, Jonathan Leo, Bruce Levine, Loren Mosher, and Stuart Shipko  

Baute, Nicole  

BBC News  
2009  Targeting Depression Early ‘Key.’ December 07:  

2012  Felicia Boots Admits Killing Her Two Babies. October 30:  

Beasley, Michael  

Beeby, June Conway  

Behar, Ruth  


Bell, Allan  

Bell, Kirsten  

Benibgui, Michael  
2010  Mental Health Challenges and Resilience in Lesbian, Gay, and Bisexual Young Adults: Biological and Psychological Internalization of Minority Stress and Victimization. PhD dissertation, Department of Psychology, Concordia University.

Bennett, Tony, with Lawrence Grossberg, and Meaghan Morris  
2005  New Keywords: A Revised Vocabulary of Culture and Society. Malden, MA: Blackwell Publishing.

Berenson, Alex

Bernstein, Mary

Bérubé, Michael

Bezanson, Kate

Bifulco, Antonia and Patricia Moran

Bird, S. Elizabeth (ed.)

Black, Rebecca W.

Bluebird, Gayle

Boddy, Janice

Boldt, Anne, and Delia D. Nihera

Bonin, Jean-Pierre, with Louise Fournier and Régis Blais

Bon Jovi, Jon

Bono, J.J.

Bourgois, Philippe

Bourgois, Philippe, and Jeff Schonberg

Bordo, Susan
<table>
<thead>
<tr>
<th>Year</th>
<th>Title, Authors, Editors, etc.</th>
</tr>
</thead>
</table>

**Bourdieu, Pierre**


**Boyle, Theresa**


**Boynton, Petra, and Annabelle Auerbach**


**Butler, Judith**


**Bradbury, Ray**


**Bruser, David, and Andrew Bailey**


**Brean, Joseph**


**Breggin, Peter R.**


**Breggin, Peter R., and David Cohen**


**Brennan, Richard J.**


**Brewis, Alexandra A., with Daniel J. Hruschka, and Amber Wutich**


**Briggs, Laura**


**Brock, Adrian C.**


**Brodkin, Karen, with Sandra Morgen, and Janis Hutchinson**


**Brown, N.**


**Brown, Angela K.**

Canadian Press

Caplan, Paula J.

Capponi, Pat

Capps, Lisa

Capps, Lisa, and Elinor Ochs

Caputo, Gail A. and Anna King

Caulfield, Timothy, and Colin Feasby

Carey, Benedict

Carlisle, Linda V.

Carmichael, David

Carr, E. Summerson

Carrel, Alexis

CBC News
CBC/Radio-Canada

Centre for Addiction and Mental Health (CAMH)

Césaire, Aimé

Chabasinski, Ted

Chamberlain, Linda

Chamberlin, Judi

Chander, Anupam and Madhavi Sunder

Chesler, Phyllis

Chhachhi, Amrita and Renée Pittin

Chong, Patricia

Chua, Jocelyn Lim

Chung, Andrew

Clarke, J.N. and M.M. Everest

Clarke, Juanne, and Adele Gawley

Clarke, Liam
Clay, Sally  

Cloud, John  

Coalition Against Psychiatric Assault  

Cockburn, Patrick, and Henry Cockburn  

Cody, Patrick  

Cohen, Alex, with Arthur Kleinman, and Benedetto Saraceno  

Cohen, Robin and Shirin Rai  

Coleman, E. Gabriella  


College of Physicians and Surgeons of Ontario  

Collins, Anne  

Collins, John, and Ross Glover (eds.)  

Conrad, Peter, and Valerie Leiter  

Cosgrove, Lisa, with Sheldon Krinsky, Manisha Vijayraghavan, and Lisa Schneider  
2006 Financial ties between DSM-IV panel members and the pharmaceutical industry. Psychotherapy and Psychosomatics 75: 154-160.

Costa, Lucy  

Cotter, Colleen  

Cowan, Douglas E., and David G. Bromley  

Coyle, Jim  


Cancer, Amy

Cresswell, Mark

Crossley, Nick

Crumlish, N., with P. Whitty, M. Kamali, M. Clarke, S. Browne, O. McTigue, A. Lane, A. Kinsella, C. Larkin, and E. O’Callaghan

CTV News

Curtis, Ted, with Robert Dellar, Esther Leslie, and Ben Watson

Dain, Norman

Danforth, Scot, and Navarro, Virginia

Danziger, Kurt

Darcas, Anne

Dave, Naisargi N.

Davey, Monica, and Gardiner Harris

David, Aaron

David, Anthony S.


Eberly, Susan Schoon

Ecks, Stefan, and Soumita Basu

Edelman, Marc

Eghigian, Greg

Eguchi, Shigeyuki

Elbogen, Eric B., and Sally C. Johnson
2009 The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Archives of General Psychiatry 66 (2): 152-161.

Ellis, Donna Lloyd

Embree, Valerie

Escobar, Arturo

Estroff, Sue E.

Estroff, Sue E., with William S. Lachicotte, Linda C. Illingworth, and Anna Johnston

Everett, Barbara

Fabris, Erick

Fairclough, Norman

Fanon, Frantz

Farmer, Paul

Fassin, Didier
Fasting for Freedom

Fergusson, Dean, with Steve Doucette, Kathleen Cranley Glass, Stan Shapiro, David Healy, Paul Hebert, and Brian Hutton

Fierlbeck, Katherine

Firestar, Morgan

Fitch, E. Frank

Flacks, Diane

Flacks, Richard

Fletcher Jr., Bill, and Richard Hurd

Foley, Nancy

Foster, Adriana, with Del D. Miller, and Peter F. Buckley

Foucault, Michel

Fox, Catherine O. and Tracy E. Ore

Frank, Leonard Roy

Frank, Leonard Roy (ed.)

Fraser, Nancy

French, J., with A. Khan, and H. White
Fridely, Mary

Friedman, Jonathan

Funk, Wendy

Furler, John, with Renata Kokanovic, Christopher Dowrich, Danielle Newton, Jane Gunn, and Carl May

Gabriel, Yiannis

Gaines, Victoria D.

Gamson, Joshua

Gamson, William A., and David S. Meyer

Garcia, Angela

Gartrell, Nanette

Gee, James Paul

Geisler, Robin, and Don Weitz

Gellad, Ziad F., and Kenneth W. Lyles

Genereaux, Gary

Gerschon, Ilana


Gilmour, R.J., with Davina Bhandar, Jeet Heer, and Michael C.K. Ma (eds.)

Ginsburg, Allen
Glaser, Gabrielle

GlaxoSmithKline

Glick Schiller, Nina and Georges Eugene Fouron

Globe and Mail

Goldacre, Ben
2012 The Drugs Don’t Work: A Modern Medical Scandal. The Guardian, September 21:

Gollhaer, David

Good, Byron J.

Goodman, Amy, and Gabor Maté
2010 Dr. Gabor Maté on the Stress-Disease Connection, Addiction, Attention Deficit Disorder and the Destruction of American Childhood. Interview Transcript. December 24:

Goodwin, Jeff, with James M. Jasper, and Francesca Polletta

Gooldin, Sigal

Goodman, Jesse A., with Lois E. Krahn, Glenn E. Smith, Teresa A. Rummans, and Thomas S. Pileggi

Gordon, Andrea

Gotch, Bob

Gottstein, Jim

Government of Ontario
Gregg, Jessica L.  

Gremillion, Helen  

Grey, Josephine  

Griffiths, Alison  

Ha, Sejin, and Yun Jung Lee  

Hacking, Ian  

Haenfler, Ross  

Hage, Ghassan  

Haghighat, Rahman  

Halberstam, Judith  

Hall, Jamie  

Hall, Joseph  

Hall, Mark A., and Carl E. Schneider  

Hall, Will  

Harding, Anne  

Harmon, Jody A.  

Harris, Eric  


Hayes, Dennis and Robin Wynyard (eds.) 2002 The McDonaldization of Higher Education. Westport, CT: Bergin & Garvey.


Henderson, Helen

Henry, Frances, and Carol Tator

Herman, Edward S. and Noam Chomsky

Herman, Ellen

Hess, David J.

Hevesi, Dennis

Hewitt, John P. with Michael R. Fraser and Leslie Beth Berger

Himelhoch, Myra Samuels, and Arthur H. Shaffer

Hindess, Barry

Hirsch, Sherry, with Joe Kennedy Adams, Leonard Roy Frank, Wade Hudson, Richard Keene, Gail Krawitz-Keene, David Richman, and Robert Roth (eds.)

Hoffman, Lisa, with Monica DeHart and Stephen J. Collier

Hogan, Molly

Hogle, Linda F.
2002 Introduction: Jurisdictions of Authority and Expertise in Science and Medicine. Medical Anthropology 21 (3-4): 231-246

Honey, Kim

Hopkins, Mary Carol

Hopper, Kim


Hornstein, Gail A.

Kimmel, Michael  

King, Martin Luther  

Kingdon, John W.  

Kirmayer, Laurence J.  

Kirmayer, Laurence J., and Ellen Corin  

Kleiner, Kurt  

Kleinman, Arthur  

Kleinman, Daniel Lee, and Lawrence Jack Cohen  

Kluger, Jeffrey  

Knowles, Caroline  

Köhler, Nicholas  

Kolocotronís, Cyril Athana  

Koshikawa, Noriaki, with Satoshi Fujita, and Kazunori Adachi  

Krantz, David L.  

Kravetz, Shlomo, with Miriam Faust, and Michal David


Lee Badgett, M.V.

Lemonick, Michael D.

Lerner, Barron

Levison, Jennifer Rebecca

Lewis, Bradley

Lexchin, Joel

Lexchin, Joel, and Barbara Mintzes

Li, David

de Lima, Roberto Kant

Lippman, Walter

Lippman, A.

Liptak, Adam

Littlewood, Roland

Liu, Yvonne Yen

Livingston, Julie

Lloyd, Genevieve
Lock, Margaret  

Loomba, Ania  

Louis, Brad  

Lupton, Deborah  

Luhrmann, T.M.  

MacCharles, Tonda  

Maclean’s  

Maddock, Mary and Jim Maddock  

Madness Network News Collective  

Mad Pride Organizing Committee  
2009 Mad Pride Week 2009 Souvenir Program. Toronto: C/S Info Centre.  
2010 MAD PRIDE Toronto 2010 program. Toronto: Mad Pride Toronto.

Mahone, Sloan  

Mahone, Sloan, and Megan Vaughan (eds.)  

Maller, Cecily, with Mardie Townsend, Anita Pryor, Peter Brown, and Lawrence St. Leger  

Mamah, Daniel, and Deanna M. Barch  

Mancini, Michael A. and Rebecca Rogers  

Mandziuk, Roseann M.  
Marcus, George E.

Markman, Allen, and Samuel Delany

Markowitz, Fred E.

Marley, James A., and Sarah Buila

Marlow, Iain, and André Picard

Marmot, Michael, with Sharon Friel, Ruth Bell, Tanja A.J. Houweling, and Sebastian Taylor, on behalf of the Commission on Social Determinants of Health

Martin, Emily

Mattingly, Cheryl

Maxmen, Jerrold S.

Maxwell, Glynis

Maxwell, Krista

Mayr, Andrea, and David Machin

McCabe, Rosemarie, and Ethel Quayle

McCall, Leslie

McCallum, Kerry

McCarthy, John

McCarthy John D. and Mayer N. Zald

McChesney, Robert


McCulloch, Jock


McDermott, R.P.


McElhinny, Bonnie


McElhinny, Bonnie, with Marijke Hols, Jeff Holtzkener, Susanne Unger, and Claire Hicks


McElhinny, Bonnie with Valerie Damasco, Shirley Yeung, Angela F. De Ocampo, Monina Febria, Christianne Collantes, and Jason Salonga


McGraw, Sarah A., with Mary Jo Larson, Susan E. Foster, Marilyn Kresky-Wolff, Elizabeth M. Botelho, Emily A. Elstad, Ana Stefancic, and Sam Tsemberis


McIntyre, Mike


McKinnon, Brian


McLaughlin, Terence


McLennan, Gregor


McLlroy, Anne

Meagher, David J., with Alasdair M.J. MacLullich, and Jouko V. Laurila

Mechanic, David, with Donna McAlpine, Sarah Rosenfield, and Diane Davis

Melucci, Alberto

Memmi, Albert

Mental Health Commission of Canada (MHCC)

Mental Health Commission of Canada Service System Advisory Committee
2009 Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups. Available at: http://www.camh.net/Public_policy/Public_policy_papers/consultation_mhcc_feb09.html, accessed 30 April 2012.

Mental Patients’ Rights Association

Metzl, Jonathan

Meyer, David S.

Miller, Daniel

Miller, Jonathan

Milne, Celia

MindFreedom International

Mock, Kathleen

Monahan, J., and J. Arnold


Nelson, Hilde Lindemann

Nelson, Jennifer and Teresa Macias

Nerlich, Brigitte, and Christopher Halliday

Nerlich, Brigitte, with Robert Dingwall, and Paul Martin

Network to Abolish Psychiatry

Neugeboren, Jay

Newspapers Canada


No Comment Dept.

Noam, Eli M.

Nothing to Lose But Our Stigma

Oaks, David W.

Obeyesekere, Gananath

Ochs, Elinor and Lisa Capps

Ochs, Elinor and Carolyn Taylor
O’Connell, Daniel C. and Sabine Kowal

Office of the Auditor General of Canada

Ogilvie, Megan

Olstead, Riley

O’Mahony, P.D.

O’Melinn, Liam Seamus

Ontario Human Rights Commission

Ontario Ministry of Community and Social Services

Ontario Ministry of Health and Long-Term Care


Ottosson, Jan-Otto, and Hakan Odeberg

Owen, Michael J., with Nick Craddock, and Assen Jablensky

Packard, E. P.W.

Pajnik, Mojca, and John D.H. Downing (eds.)

Parekh, Bhikhu

Paris, Joel
Patton, Cindy  

Perantie, Dana C., and E. Sherwood Brown  

Perring, Christian  

Perry, Donna L.  

Petersen, Alan, and Deborah Lupton  

Petryna, Adriana and Arthur Kleinman  

Pfizer Inc.  

Philo, Greg  

Phoenix Rising Editorial Collective  
1980c  Giving Them the Bird 1 (2): 4  

Piat, Myra, with Judith Sabetti, and David Bloom  
2009  The Importance of Medication in Consumer Definitions of Recovery from Serious Mental Illness: A Qualitative Study. Issues in Mental Health Nursing 30 (8): 482-490.

Picard, André  

Pichardo, Nelson A.  

Pilgrim, David  

Porcelli, Stefano, with Antonio Drago, Chiara Fabbri, Sara Gibiino, Raffaella Calati, and Alessandro Serretti  


Psychiatric Survivor Archives of Toronto 2011 “Stick With It. We’re All In It Together.” Voices: Newsletter of the Psychiatric Survivor Archives of Toronto 2 (1): 2-3, 6-10.


Quebec Cancels 1985 Madness Network News 7 (5): 6


Read, J., with N. Haslam, L. Sayce, and E. Davies

Reger, Jo, and Suzanne Staggenborg

Reid, Jenna

Reilly, J.G., with S.A. Ayis, I.N. Ferrier, S.J. Jones, and S.H.L. Thomas

Reith, Gerda

Reitman, Janet

Reaume, Geoffrey

Relman, Arnold S.

Rempel, Shauna

Ries, Nancy

Riessman, Catherine Kohler

Rissmüller, David J., and Joshua H. Rissmüller

Robertson, Emily

Robinson, Ian

Rock, Melanie

Roe, David, and Max Lachman

 Rogler, Lloyd H.

 Rose, Nikolas

 Rose, Nikolas, and Carlos Novas

 Rosedale, Mary

 Rosenberg, Charles

 Rosenhan, D.L.

 Roses, Allen D.

 Rosner, Mary, and T.R. Johnson

 Roth, Robert T. and Judith Lerner

 Roth, Robert T., with Melvin K. Dayley, and Judith Lerner

 Roy, Mallarika Sinha

 Roy, Srila

 Sackheim, Harold A., with Joan Prudic, Rice Fuller, John Keilp, Philip W Lavori, and Mark Olfson

 Sadowsky, Jonathan

 Samelson, Franz

Sanbower, Martha

Sansone, Randy A., with Lori A. Sansone, and John L. Levitt

Sapinsley, Barbara

Saris, A. Jamie

Savage, Harvey, and Carla McKague

Savage, Larry, and Dennis Soron

Schepet-Hughes, Nancy

Schizophrenia Society of Ontario

Schlosser, Allison V., and Kristi Ninnemann

Schwartz, R.C.

Scull, Andrew

Select Committee on Mental Health and Addictions, Ontario Legislative Assembly

Shapiro, Joseph P.

Sharfstein, Steven S.

Shaughnessy, Pete

Shepherd, Michael

Shimrat, Irit

Shore, Cris and Susan Wright

Shorter, Edward

Showalter, Elaine

Shumka, Leah and Cecilia Benoit

Sirois, François

Small, Peter
2009  Intelligence Masked MD’s Illness, Court Told. Toronto Star, February 26: GT3.

Smardon, Regina

Smith, Daniel B.

Smith, Leonard D.

Smith, Scott

Sone, Abigail

Sparkes, Andrew C.
Spiegel, Alix

Spitulnik, Debra

Spurgeon, David
2008 Stigma Associated with Mental Illness in Canada is a National Embarrassment. BMJ 337: a1447

Standing Senate Committee on Social Affairs, Science and Technology (SSC)

Starkman, Mel

Starkman, Randy

Stoppard, Janet M., and Deanna J. Gammell

Stoppard, Janet M., and Linda M. McMullen (eds.)

Strathern, Marilyn

Straus, Sabine M.J.M., with Gysèle S. Bleumink, Jeanne P. Dieleman, Johan van der Lei, Geert W. ‘t Jong, J. Herre Kingma, Miriam C.J.M. Sturkenboom, and Bruno H.C. Stricker

Streck, Bernhard

Stoler, Ann Laura

Summerfield, Derek

Suri, Rochelle

Survivors’ History Group

Swartz, Sally

Szasz, Thomas

Szmigiero, Katarzyna

Tannen, Deborah

Tanner, Lindsey

Taylor, Bill
2009a Trick of the Cards or of the Mind? Toronto Star, May 02: U6.

Taylor, Janelle S.

Taylor, Lesley
2009b Clue Found To Depression: Sufferers See Borders of Objects Differently. Toronto Star, December 04: L4

Taylor, Paul

Tenth Annual Conference on Human Rights and Psychiatric Oppression

Teotonio, Isabel

Thomas, Katie, and Michael S. Schmidt

Tickle, Don

Tilley, Susan A.

Titchkosky, Tanya

Tomes, Nancy

Touraine, Alain

Toronto Central Local Health Integration Network (LHIN)

Toronto Star editorial board

Toronto Star wire services

Torrey, E. Fuller

Torstar Corporation

Tranulis, Constantin S., with Oliver Freudenreich, and Lawrence Park

Trimble, Michael, and Mark S. George

Tucker, Gary J.

Tyler, Tracey

Tyrer, Peter, and Tim Kendall

United States Food and Drug Administration (FDA)

Urdaniz, A.P., with F.M.V. Fernandez, N.M. Navarro, R.M. Ramos, I.M. Terron, and V.R. Larrosa

Valentine, Gill

Van Vleet, Krista E.

Vaughan, Megan

Velpry, Livia

Vitti, James

Wang, Philip S., with Olga Demler, and Ronald C. Kessler

Wardlow, Holly


Warin, Megan

Weeks, Carly

Weiner, Talia

Weismantel, Mary J.

Weitz, Don

Wessely, Simon, and Robert Kerwin
2004  Suicide Risk and SSRIs. JAMA 292: 379-381.

West, Candace

Wilson, Carol

Wilson, Samuel M. and Leighton C. Peterson

Whitaker, Robert

White, Kimberley

Whitley, R., with L. Kirmayer, and D. Groleau

Whittier, Nancy

Whooley, Owen

Wilkins, Amy

Williams, Gareth

Williams, Raymond
1976 Keywords: A Vocabulary of Culture and Society. London: Croom Helm.

Wilson, Samuel M., and Leighton C. Peterson

Windfuhr, Kirsten, with Pauline Turnbull, David While, Nicola Swinson, Hetal Mehta, Kelly Hadfield, Urara Hiroeh, Helen Watkinson, Clare Dixon, Sandra Flynn, Simon Thomas, Glyn Lewis, I.N. Ferrier, Tim Amos, Petros Skapinakis, Jenny Shaw, Nav Kapur, and Louis Appleby

Wingerson, Lois

Winsa, Patty

Wodak, Ruth and Paul A. Chilton

Wolf, Naomi

de Wolff, Alice

Woodworth, Garth
2009 Public the Public Interest First: Corporations Can and Should Be Made Socially Responsible. CCPA Monitor 15 (8): 1, 12-17.

Wool, Zoë

Wooltorton, Eric

World Health Organization (WHO)


Wright, L.

Wright, N., with P. Bartlett, and P. Callaghan

Yew, Madhavi Acharya-Tom

Young, Allan

Youssef

Yukhananov, Anna

Zimmerman, Fred

Zimmermann, Ulrich, with Thomas Kraus, Hubertus Himmerich, Andreas Schuld, and Thomas Pollmächer