# *Sessions, Speakers, Co-Authors, and Abstracts*

## SESSION 1.
## *Rehabilitating 'The System': Global Stories of Regulation, Recovery and Empowerment*

**Michael Wearing.** Social Sciences and International Studies, University of New South Wales, Sydney, NSW, Australia

### *Professional Governance and Psychiatric Knowledge in Australian Mental Health Practice – Examining Discourses of Recovery and Consumerism in the Health Care Professions*

This paper will explore the constructions of mental health workforce competences and standards in Australia with reference to other countries such as the USA and New Zealand. A range of professional and governmental discourse on standards is explored including scientific and psychiatric accounts, and consumer perspectives derived from lay and experiential narrative and participation. The use of psychiatric knowledge in mental health services and by professionals is defined in part by the ability to classify and govern others with a highly specialised and 'scientistic' knowledge. This governance of 'illness' is outlined in a brief history of psychiatry and related bio-behavioural paradigms. This paper deals with specific constructions of 'recovery' and consumerism in the health care professions including nursing, psychology and social work. This remains an under-examined area of health and allied health work. Professionalisation is then discussed in relation to issues of medical dominance and psychiatrization in the delivery of services, and how such coded knowledge is translated and disseminated into training programs, formal learning and professional practice.

In this framework, professional governance of the mentally ill is conceived mostly as a reactive set of discourses that in neo-liberal and residual welfare states seeks to regulate against risk and danger, and perpetuate fears of the 'constructed other'. To challenge new modes of regulation of illness a careful path for mental health professionals is suggested using a reflexive knowledge and ethics with an emphasis on consumer participation where identity and difference are respected. Drawing on recent work (Wearing 2005, Hughes and Wearing 2007), the author argues that upwards, sideways and internal shaping of human and health service organizations by participatory and more democratic use of knowledge/power will challenge dominant and objectifying knowledge about mental health clients in these services. Understanding how multiple forms of professional knowledge govern practice can reframe thinking on both the effects of psychiatric knowledge and professional interaction with consumers.

**Simon Davis.** Vancouver Community Mental Health Services, and Social Work and Family Studies, University of British Columbia

*The "Recovery" Vision and Risk-Aversion in Psychiatric Service Delivery: Thoughts on the Reconciliation of Competing Perspectives*

Currently in North America reference is being made to a "recovery" vision in the delivery of mental health services. This is a model that would emphasize holistic care and collaboration; autonomy, empowerment and risk-taking among service recipients; and a hopeful attitude among service providers. There are a number of barriers to implementation of this vision, including a tradition of medical paternalism, and a corporate culture that is "risk-averse." This presentation (i) gives a history and explication of the "recovery" concept, (ii) reports on data from a study of system "recovery fidelity," and (iii) speaks to a possible reconciliation of risk aversion and empowerment in service delivery.

**Ana Stefancic.** Sociomedical Sciences, Mailman School of Public Health, Columbia University

*The Role of Non-Profit Social Service Agencies in Enhancing Citizenship for Persons with Psychiatric Disabilities*

Persons with severe mental illness, particularly those who experience homelessness, encounter multiple obstacles to enhancing their citizenship, with citizenship understood both as membership status and participatory process. Within public mental health, service agencies are increasingly expected to help advance consumers' goals of social integration and citizenship. This presentation suggests how agencies and services may be restructured so that "program citizenship" can serve as a path to full citizenship as opposed to a marginalized alternative. Agencies can assist consumers to achieve participatory parity (Fraser, 2003) by facilitating access to resources, developing individual capacities, connecting consumers to venues in which those abilities can be exercised, and engaging in advocacy and community development. As such, participation and citizenship can be enhanced in four domains: 1) individual services; 2) agency operations; 3) the mental health treatment system; and 4) social, civic and political realms. Janoski's (1998) model of citizenship and a Capabilities approach to disability (Mitra, 2006; Hopper, 2007) will inform the presentation. A Housing First program that provides independent housing and consumer-driven services without treatment prerequisites will be used to provide concrete examples of such efforts and potential barriers.

**Daniela De Vito.** Crucible Centre, Roehampton University

## *Who Belongs as Citizens? The Realities of Refugees and Asylum Seekers with Post Traumatic Stress Disorder*

Refugees and Asylum seekers have often been placed at the margins of or excluded from political institutions and society. Whether these individuals find themselves in refugee camps, in situations of detention, in so-called refugee processing centres, or living within society awaiting their asylum claims to be processed or with refugee status, belonging as citizens may be considered extremely difficult or virtually impossible. Furthermore, the realities faced by refugees and asylum seekers who suffer from Post Traumatic Stress Disorder (PTSD) contribute to the difficulties in accepting these individuals as citizens. However, this paper will argue that despite these perceptions and realities it is possible to consider that refugees and asylum seekers belong as citizens. The paper will take an inter-disciplinary approach and will draw on the conceptual resources of political theory analysis while incorporating real life situations within the theoretical assessment.

First, a distinction will be made between 'belonging as citizens' and 'having citizenship rights'. The aim will be to emphasise that having a formal claim to citizenship may not necessarily be a requirement for belonging as a citizen. The work of Seyla Benhabib will be a starting point for this discussion. For instance, Benhabib writes about re-formulating citizenship beyond national membership and uses the term 'citizenship of residency'. Second, while acknowledging and appreciating the implications of placing individuals within such categories, the definitions of refugees and asylum seekers as understood under current international refugee law will be outlined. This is important since a refugee and an asylum seeker experience different realities in conjunction with the process of belonging as a citizen. For instance, the asylum seeker whose claim is being processed is in a state of limbo and may find opportunities to belong as a citizen more difficult than the refugee. Where the individual finds himself/herself – such as in a camp, etc. - will have an impact on the process. In addition, the constraints presented by psychiatric labels such as PTSD in relation to refugees and asylum seekers will be outlined and challenged. Third, real life examples will be utilised to argue that one manner in which refugees and asylum seekers can belong as citizens is through participation. Of course, whether or not access to participation is available or if these individuals can participate as equals within political structures or society will be examined. One such example, which will demonstrate different levels of participation and perhaps belonging as citizens, is the group of Sudanese asylum seekers who organised a demonstration in London highlighting the situation in Darfur (Sudan) and who pressed for the United Kingdom government and the international community to intervene in the conflict. Such participation, and therefore belonging as citizens, could be located within a multi-faceted and non-formal approach to citizenship.

## SESSION 2.
## *Feminist Dialogues on Women, Madness, Language and Power*

**Jane M. Ussher.** Gender, Culture and Health Research Unit, University of Western Sydney, Australia

### *The Construction and Regulation of Women's Madness: Managing the Monstrous Feminine*

This paper will examine the construction, regulation, and experience of the women's madness, focussing on the positioning of transgression from ideals of hegemonic femininity as embodied pathology, which acts to maintain fears of the monstrous feminine within. Drawing on interdisciplinary theory and interviews conducted with women in the UK and in Australia, I will examine the ways in which women negotiate the contradictory discourses associated with the pathologised fecund body, and the impact this has on their embodied subjectivity; their taking up of the subject position 'woman'.

Self-surveillance and disciplinary regulation of the reproductive body starts at menarche, with menstrual blood positioned as sign of contamination, requiring careful concealment and adherence to hygiene rules. Pregnancy is positioned as a 'normal illness', the body a mechanical object subjected to medical surveillance and intervention, fecundity under technological control. In the case of the reproductive syndromes - Premenstrual Syndrome (PMS), Postnatal Depression and Climacteric Syndrome - the problem is located within: the monster in the machine of femininity positioned as endocrine or neurotransmitter dysfunction, or 'female sex hormones', a pathology within the woman, outside of her control.

Yet women are not passive in this process of regulation. They do have the capacity for agency; for negotiation and resistance of the discursive positioning of fecundity as sign of abjection. This paper will examine this process, and explore the implications of this analysis for theory and practice within psychiatry and psychology.

**Leslie Roman.** Educational Studies, University of British Columbia

### *In/visible: Indivisible?: Barriers, Accomodations and Epistemic Rightful Places*

One of the formidable and parodoxical challenges remaining for rights'-based groups struggling for equality concerns how to recognize and work for the specific set of needs, resources and challenges faced by women with invisible disabilities. On many fronts, particularly in some racially and class-specific places in the West, women with disabilities have won some significant gains, including deinstitutionalization, the abolition of compulsory sterilization laws, and waged workplace physical accomodations. The 'last civil rights movement' of disability rights has led to anti-discrimination and human rights legislation that specifically include disability. For example, disability has been included as one of the four protected Charter groups in Canada. Yet, partly because rights'-based talk and discourses depend on materializing *visible* subjects, women and persons with physical disabilities or impairments have been privileged in the realm of epistemic rights-based claims-making over those with invisible impairments. Thus, women with invisible impairments--whether mental, emotional, developmental, chronic, etc.) often find themselves to occupy the ambiguous netherlands, stigmatized subaltern and border-land spaces that do not result in the discourses to make rights-based claims for sexual rights, waged workplace or unpaid work and home healthcare accomodations. Drawing on a textual analysis of photographs and images used in campaigns to fight for women and persons with disabilities internationally and nationally in Canada in the last thirty years, the paper will show such images have figured disability and impairment primarily as physical. It will also show how the all too rare address of invisible impairments has been nearly equated or reduced to stigmatizing images of particular mental health campaigns, thus neglecting many other forms of invisible impairment or disability. Drawing on Rod Michalcho's (2007) notions of "semiotic excess" and "insufficiency" women with invisible impairments remain in an ambiguous netherland and yet stigmatized subaltern border-land, neither persons nor visible subjects. This paper will argue that the campaigns nationally, as well as internationally to enfranchise women with disabilities have often reproduced a subaltern space or borderland for women with invisible disabilities, who find themselves/ourselves left out of the considerations and discourses that that construct rights'-based struggles and the subjects of human rights campaigns. Probing how this last ghetto of social justice works through a particular semiotics of the visible subject, even the discourse of 'passing' becomes problematic. By way of an alternative, the paper asks: how might feminist disability campaigns creatively work for strategic 'structural registers of voice' (Roman, 2003) and disruptions of the visible iconography to be epistemically heard and enfranchised. The paper explores what challenges remain for women with invisible disabilities to be included in rights'-based efforts for equality, voice, recognition and accomodations. This paper will draw autobiographically on the feminist disability literature to substantiate the border-land and last frontier argument and offer some political strategies for engaging a politics of what I call 'structural registers of voice' in epistemic and rights-based claims-making to overcome the particular challenges to the meaning of sexual rights, waged and unwaged workplace rights and accomodations.

**Katherine Teghtsoonian.** Studies in Policy and Practice, University of Victoria

*Responding to Depression in the Workplace and Beyond: A Feminist Analysis of Discourse and Policy*

During the past decade in Canada employers, researchers, and non-governmental organizations have expressed a keen interest in developing strategies for responding to the growing number of employees with depression and the significant economic costs to employers associated with this trend. In this paper I draw on feminist analyses of neoliberalism and of mental distress, as well as the Foucauldian literature on governmentality, to engage critically with the manner in which the problem of depression in the workplace has been framed, and the responses to it that are being proposed. I argue that key features of contemporary discourses and emerging initiatives regarding "workplace depression" intersect with the lives of diverse groups of women in ways that pose challenges to their social citizenship: by individualizing the sources of mental distress and responses to it, by contributing to the privatization of access to health care benefits, and by developing potentially problematic linkages between the public world of employment and employees' private lives.

**Andrea Nicki.** Independent Scholar, Women's Studies and Gender Relations, University of British Columbia

### *Rethinking Female 'Personality Disorders': Recovering Moral Agency*

Much research on female "personality disorders" sees those diagnosed with them from a non-holistic, exclusionary perspective, perceiving and evaluating them in terms of ideals that guide "normal" personalities. Feminist psychiatrist Judith Herman argued a few decades ago that "borderline personality disorder," for instance, should be re-envisioned as complex post-traumatic stress disorder. But feminist critiques, such as that of Herman, have been continually ignored in both psychiatric theory and practice. There is little attempt to understand the moral worlds of people with complex post-traumatic stress disorders, and their behaviour, attitudes, and achievements are often reduced to mere symptoms. I show that it is important to maintain a distinction between mental health and moral virtue; though the two may influence each other, there is no necessary causal relationship between them. I am concerned with the basic task of affirming the personhood, rationality, and moral agency of women who have been dehumanized by psychiatric conceptions. In order to challenge dominant views of women with complex post-traumatic stress disorders, I explore narratives of female survivors of chronic childhood abuse as counterstories that tell stories of moral possibilities and healing.

## SESSION 3.
## *Criminological Madness*

**Leanne Dowse and Eileen Baldry.** Social Sciences and International Studies, University of New South Wales, Sydney, NSW, Australia

### *Turning the Key: Conceptualising the Community/Corrections Continuum for People with Mental Health Disorders in the Criminal Justice System*

The growing presence of people with mental health disorders in criminal justice systems (CJS) worldwide is of public concern. An innovative Australian study linking data from CJS and human service agencies is providing detailed descriptions and analyses of the pathways by which people with mental health and particularly complex disorders enter, move through, exit and return to the CJS. Early insights from the study indicate the importance of an integrated conceptualisation of justice, social and health involvements that moves beyond previous compartmentalised, analytic approaches. It recognizes corrections, courts, police and the community as part of a fluid or porous and looped *continuum* for these persons. This conceptualisation provides a new understanding of how these persons are moved into the CJS, maintained there and rendered invisible in the broader social and body politic.

**Judith Mosoff.** Law, University of British Columbia

### *Mental Health Courts in the Criminal Justice System: Substantive Equality, Coercion or Paternalism*

This paper looks at the tension between therapeutic jurisprudence and the social model of disability in the context of mental health courts in the criminal justice system. Beginning in the U.S .in 1989 with courts for drug addicts, specialty courts now exist in the U.S. and Canada for a wide variety of populations and offences, including courts specifically geared for persons with psychiatric disabilities. Unlike typical courts characterized by the adversarial system and a focus on the determination of guilt, these “problem-solving” courts use a team approach to address an underlying problem that has led to criminal behaviour. Largely motivated by American drug policy, the new approach may be problematic in other contexts, and in other jurisdictions. Underpinning the new courts is therapeutic jurisprudence, a set of ideas suggesting that law has an inevitable effect on participants in legal matters, and where possible, therapeutic opportunities should be used for their benefit. In the area of disability these new legal institutions may solve some problems, but certainly raise others. For example, the team model, historically paternalistic or coercive, eclipses the usual adversarial criminal process. Other concerns include the muted role of defence counsel, allowing access to scarce mental health resources only for criminal behaviour, and frequently, an explicit requirement of a guilty plea in order to participate. In a variety of ways, these courts represent a triumph of the medical model: pathology is affixed to the individual, the mandate of the court is to encourage treatment and the opinions of medical professionals are usually decisive. On the other hand, the accused with a psychiatric disability does very poorly in the conventional criminal justice. In this paper I suggest that an equality lens be used to evaluate the wisdom of establishing specialized mental health courts in the criminal justice system.

**Jonathan M. Metzl.** Psychiatry and Women's Studies; Director, Program in Culture, Health, and Medicine, University of Michigan

*Protest Psychosis: Race, Stigma, and the Diagnosis of Schizophrenia*

Misperceptions that persons with schizophrenia are violent or dangerous lie at the heart of stigmatizations of the disease. My project tells the story of how these modern-day American conceptualizations of schizophrenic patients as violent emerged during the civil-rights era of the 1950s-1970s in response to a larger set of conversations about race. I integrate institutional, professional, and cultural discourses in order to trace shifts in U.S. popular and medical understandings of schizophrenia from a disease of white docility to one of "Negro" hostility, and from a disease that was nurtured to one that was feared. The first and longest section of the paper tracks the medicalization of race and schizophrenia within a particular institution, the Ionia Hospital for the Criminally Insane. I access an extensive archive of medical records and administrative documents to show that, starting in the 1950s, schizophrenia became a diagnostic term disproportionately applied to the hospital's growing population of African American men for reasons having as much to do with perceived threats of violence as with criteria for mental illness. I also show how evolving notions of violence shaped, and were in turn shaped by, changing notions of institutional space. Section two contextualizes the Ionia case histories within shifting psychiatric definitions of schizophrenia, as read through an extensive analysis of published case studies. The final section reads shifts in psychiatric nosology within changing American cultural concerns about black masculinity. I show how civil-rights era debates about the role of violence in promoting social change mapped onto descriptions of schizophrenia as a violent disease.

**Diana Wendy Fitzgibbon.** Criminal Justice, Hertfordshire University, England

*Pre-Emptive Criminalisation and Black Mentally Ill People*

This paper attempts to develop an account of the dynamics of discrimination against black people in the area of mental health policy and practice. It is argued that a framework for the analysis of discrimination can be usefully constructed in terms of the relationship between the processes of pre-emptive criminalisation, risk analysis and institutional racism.

Pre-emptive criminalisation, refers to a process in which the activation of criminal justice responses in Britain, increasingly takes an anticipatory form. Thus responses, are based upon the expectation that individuals are likely to commit criminal acts in the future rather than they have already done so. The second process, risk analysis refers to the practice, now common in probation, social work, and mental health, of responding to individuals by allocating them to groups categorized in terms of the statistical likelihood of committing certain types of acts. This combines with the final process, institutional racism, the dynamic of racial discrimination which is rooted in the mode of operation of an institution. By using case material this paper will explore the impact of these three reinforcing processes in psychiatric institutions.

## SESSION 4.

## *Women's Narratives of Psychiatry, Gender, Race, Subjugation and Survival*

**Vanessa Jackson.** Healing Circles, Social Worker, Author, Atlanta, Georgia

*In Our Own Voice: African-American Stories of Oppression, Survival and Recovery*

This paper will explore the importance of history and oral history narratives as a tool for empowerment and healing for psychiatric consumers/survivors/ex-patients. The history of a people is generally told from the perspective of the dominant group, which is invested in obscuring its violations and brutality. It is an act of extreme courage and resistance for historically marginalized individuals and groups to honor our truths and our history by passing those stories on to others. A historical perspective on "mental illness" or "madness" will provide a context for how the medicalization of emotional distress allows for the invalidation of individuals deemed different by society and presents challenges to many mental health systems as they attempt to shift to self determination and recovery models of support.

**Dorothy Proctor.** Activist and Author, Toronto, Ontario

*Madness, Citizenship and Social Justice: My Story*

As an inmate at the Prison for Women during the early 1960s, I was subjected to experimentation which combined LSD, sensory deprivation, and electroshock. Along with these abuses, I experienced racism and sexism. Thirty years later, I sought justice by taking legal action against the Canadian federal government and former federal employees. In this presentation, I will share what I have learned through my struggle for social justice.

**Sue Clark-Wittenberg.** Wittenberg Center to End Electroshock, Ottawa, Ontario

*The Sue Clark Story: "Behind The Locked Ward"*

Sue Clark-Wittenberg is a psychiatric survivor who had electroshock. Sue is an antipsychiatry activist and antipoverty activist for over 20 years in Ottawa. Sue's main focus of her activism today is to help end electroshock universally.

Sue and her husband Steven founded the Wittenberg Center to End Electroshock in 2007. Sue was damaged by electroshock. Sue suffers from permanent memory loss and has difficulty learning new things.

The Sue Clark Story is a true account of Sue's traumatic childhood, her teenage years, her marriages and her activism. Sue was psychiatrized in Ontario psychiatric hospitals from the age of l7 years old in 1972 to 1990. During that time Sue was given 15 different psychiatric diagnoses and 14 different types of psychiatric drugs. Sue has been free of psychiatry since 1990. Sue helped found 3 psychiatric groups in Ottawa.

Sue worked for the Royal Ottawa Hospital in the 1990s as an antipsychiatry speaker in the Consumer as Expert Program in the Education Department co-ordinated by Marian Crow.

**Caroline Fei-Yeng Kwok.** Author, Lecturer and Teacher, Toronto, Ontario

*Madness: The Experience of an Immigrant Woman*

**BACKGROUND:** As a Chinese immigrant afflicted with manic-depression, I am well aware of the cultural, linguistic, racial issues faced by new Canadians and the fear they developed of the mental health system. I am also aware of the insensitivity of mainstream mental health in their treatments of immigrant consumers.

**OBJECTIVES:** To discuss barriers for immigrants in accessing mental health services and to suggest possible solutions.

**METHOD:** I will cite from my book, *Free To Fly: A Story of Manic Depression***,** and make references to the literature on cross-cultural psychiatry.

**RECOMMENDATIONS:** Immigrants need to overcome social stigma in regard to mental health, develop better understanding of the system, and have more knowledge about medications. Mainstream mental health services need to develop more cultural competence programs.

**CONCLUSION:** Mental health care for immigrants can be improved.

## SESSION 5.
## *Making 'Mad' Laws 1: Legal Rights, Human Rights and History*

**Lucy Costa.** Outreach Worker, Empowerment Council, CAMH, Toronto; Psychiatric Survivor Archives of Toronto

*Psychiatric Patient Rights and the Politics of "Progress"*

Most decisions that have greatly impacted the lives of psychiatric inmates have been presided over by legal experts, politicians and intellectuals. However, in the last ten years, Ontario has seen a rise in "rights talk" for psychiatric inmates, acknowledging and supporting the need for more patient self-determination.

While there has been more inclusion and influence by patients and ex-patients in political and legal processes, progress is often met with resistance and at times legislation that allows more state control. The introduction of community treatment orders in Ontario in 2000 is a case in point.

One of the means by which psychiatric survivors/mad activists gain status in legal playgrounds is to claim equality though "disadvantage". This presentation will discuss some key legal cases and "wins" for the psychiatric inmate community as well as the tensions that exist when the psychiatric survivor/mad community proceeds to intervene and negotiate legal and parliamentary combat zones.

**Tina Minkowitz.** World Network of Users and Survivors of Psychiatry, Chestertown, New York

*The Emergence of a User/Survivor Perspective in International Human Rights Law*

The drafting and negotiation of the UN Convention on the Rights of the Rights of Persons with Disabilities (CRPD) was a unique opportunity for users and survivors of psychiatry to play a role in the creation of international human rights law. Building on the slogan of the international disability movement, "Nothing about us without us," we made a place for user/survivor issues in disability and human rights advocacy, found the principles that created a common bond between us and other people with disabilities, and worked to enshrine those principles in the international human rights regime.

From a non-discrimination perspective, the CRPD guarantees recognition of legal capacity, liberty, and respect for physical and mental integrity of people with disabilities on an equal basis with others (as well as free and informed consent, the right to live in the community, the right to work, parental custody, the right to vote, and in general all human rights and fundamental freedoms). Reasonable accommodation, support measures and services are also required to make those rights effective. The rights recognized in the CRPD, if implemented, require the abolition of guardianship, forced psychiatry and other such deprivations of liberty and self-determination linked with disability. In the CRPD discussions, forced psychiatric interventions were named as torture, but due to various factors our proposed language did not stay in the final text. However, a year after the adoption of the CRPD, the UN Office of the High Commissioner for Human Rights held a seminar in which this topic was considered by torture experts, and it is an emerging issue in human rights advocacy. Recognizing forced psychiatry as torture or cruel, inhuman or degrading treatment or punishment will be a significant step forward in making this human rights violation visible as a matter of international law.

Users and survivors of psychiatry face great challenges in implementing the Convention, due to skepticism, lack of familiarity or understanding, hostility and discrimination, and entrenched interests that stand to lose professionally or financially if our rights are fully respected. But with the Convention, we have matured into a new phase of advocacy as recognized human rights defenders, with the backing of an international legal instrument and visibility at the United Nations. Advocates need to understand the Convention and its implications for their work, in order to take advantage of new opportunities to bring about our vision of a world where we can live freely and be accepted as we are, with or without support according to our own choices.

This presentation will discuss the role played by users and survivors of psychiatry in the drafting and negotiation of the UN Convention on the Rights of Persons with Disabilities, and in continuing advocacy to make our human rights real. We will discuss the relevant provisions of the CRPD as well as the argument that nonconsensual psychiatric interventions amount to torture or cruel, inhuman or degrading treatment or punishment. If time permits, we will address any emerging issues or challenges currently under way.

**Tiffany F. Jones.** History, California State University, San Bernardino

*Murderers, Madmen and Practitioners: The Legacy of Apartheid on South Africa's Mental Health and Criminal Justice System*

There is a crisis currently in South Africa's judicial and mental health care system. Three hundred potentially criminally insane individuals are awaiting trial who have been housed for over a year in prison before they can be observed for the legally-prescribed thirty day period in an observation ward at various mental institutions. Reports of murders by released patients have increased over the past few years, and practitioners have admitted to having to release potentially "unstable state patients" prematurely because of the lack of resources" (Maughan, 2006: 6). This situation is not new, however. Throughout the apartheid years, government policies contributed to similar human rights violations and formed the foundation upon which present-day policy is established. This paper, therefore examines forensic psychiatric policies and practices during apartheid. In doing so, it asserts that South Africa's mental health institutions and psychiatrists were not simply, as scholars in other historical circumstances have suggested, custodial agents of the state. In the years leading up to apartheid and thereafter, their role was much more complex. Certainly, psychiatrists played a role in apartheid hegemony, but they also shaped and challenged the old custodial and disciplinary practices of psychiatry. By examining in particular the case of Demitrio Tsafendas, who assassinated the apartheid Prime Minister, H.F. Verwoerd in 1966, we are able to view the interconnected environment where practitioners, judges, the state, and the "mad" interrelated, and we see how constructions of the "mad" were highly politicized, confused, often contradictory and shaped by the various individuals involved. An historical examination of this case also allows us to place today's crisis in perspective and offers insight into the origins and causes of these human rights abuses.

## SESSION 6.
## *Rethinking 'Mental Illness'*

**Bruce A. Arrigo.** Criminal Justice, University of North Carolina, Charlotte

### *Justice and the Representation of Mental Illness: On Power, Desire, and Culture in Ultramodern Society*

This paper explores the semiotic processes through which mental illness is manufactured in ultramodern society. By integrating the work of Foucault on power, Lacan on desire, and Baudrillard on culture, a conceptual framework that explains the territorialization of madness is proposed. This framework is then linked to how the systems of law and psychiatry behave – as reified and legitimized through the operation of the media – such that selective sign meanings for mental illness are conspicuously consumed by the public. The paper concludes by addressing the implications of power, desire, and culture in ultramodern society, especially when questions of citizenship, justice, and human rights are eclipsed by stylized and simulated hyper-real images. Case illustrations (e.g., Aileen Wuornos, Jeffrey Dahmer, Colin Ferguson) are used throughout to ground the theoretical work.

**Peter Beresford.** Centre for Citizen Participation, Brunel University

### *Developing a Social Model of Madness and Distress: Reconnecting Madness, Citizenship and Social Justice*

The focus of this presentation will be the development by mental health service users/survivors of our own social approaches to and understandings of our experience, identity and treatment. The presentation will explore the view that existing dominant medicalised understandings of mental health service users based on a model of 'mental illness' are inherently at odds with securing their citizenship and social justice. Instead they have encouraged and extended understandings of mental health service users in terms of pathology, deviance and defect. This has supported a preoccupation with bioethical interpretations and responses to their situation and encouraged reaction against the decarceration of mental health service users and pressure for the extension of restrictions of their rights internationally. The dominance of psychiatric interpretations has also inappropriately reinforced the association of violent and criminal behaviour with mental distress. This presentation will explore the development of a social model of madness and distress (contrasting it with traditional environmental understandings), building on the social model of disability, to provide an emancipatory basis for understanding and addressing the rights and needs of mental health service users and reconnecting social justice, citizenship, madness and distress. The presentation draws on a survivor controlled research project, funded by the Joseph Rowntree Foundation and jointly undertaken by the presenter, Mary Nettle and Rebecca Perring, which explores mental health service users' views about existing understandings of 'mental health issues' and their ideas about a possible social model of madness and distress.

**Helen Douglas.** Philosophy in Practice, Cape Town, South Africa

*Stranger Neighbours*

The mad ones among us would be excluded from citizenship and justice, if these were understood as based solely in relationships that are amenable to reason and regulation. But what if these concepts also arise within relations of uniqueness, proximity and ethical responsibility (Levinas)? Does madness prove the limits of justice and citizenship? Or do the ethical demands of a mad neighbour point instead to their infinite depth?

These questions open another perspective on a community's response - psychological, practical and political - to its stranger neighbours.

**Lane Robert Mandlis.** Sociology, University of Alberta

*Madness as 'Choice': The State of Exception, Responsibilization, and the Political Sphere*

This paper explores the notion of responsibilization and its application to 'mental illness' through the Diagnostic and Statistics Manual of Mental Illnesses (DSM). Bringing together the ideas of Giorgio Agamben, Judith Butler, and Nicolas Rose as a way to explore madness, this paper takes the position that responsibilization as a means of social control invokes the state of exception, and thus produces those deemed 'mentally ill' as *homines sacri* – sacred men. By exposing the commonsensical link between responsibilization and 'choice', this paper argues that 'mental illness' is actually understood to be a choice, a particularly bad one at that, with significant repercussions in the political sphere.

## SESSION 7.
## *Psychiatric Discrimination as Social Injustice*

**Erick Fabris**. Sociology and Equity Studies in Education, Ontario Institute for Studies in Education, University of Toronto

### *Not Ill or Mad?*

I would like to consider the terms Strange, Mad and Mentally Ill. I would like to say that they show us how psy discrimination and force operates. The distinction of the body as strange, as 'mad' in English society for 500 years, and as 'mentally ill' in the last 150 years, is the same production of sanism, critical or conservative, which faces psychiatric survivors and Mad people today. (I use sanism as the simple distinction between normal/sound/sane/sapient and strange/mad/insane/unwise: mentally ill). This is a lingual basis for legal discernment and control, which are practicable today by psychiatric incarceration (interbodily and intrabodily). Questions arising from psychiatric practice refer back to legal distinctions and then back to social conflict and naming of differences. As a word 'strange/mad/insane/ill' comes from familiar practices of identifying 'what is mad' in the family, at the campfire, and in the psychiatrist's office.

**Ronald Carten.** Vancouver/Richmond Mental Health Network, Vancouver, BC

### *The Citizen Transformed: Psychiatrization's Effects on the Social Status of the Individual*

*1. Detainment under the Mental Health Act of B.C.*
-The legislation that puts tremendous power in the hands of a psychiatrist and provides dubious appeal mechanisms.
-The exclusion of mental patients under the Representation Agreement Act.
-The denial of the right to informed consent as guaranteed to all BC citizens in the Consent to Care Act.
-The absence of advance directives as a means of protecting oneself against forced treatment. The Kirby Report recommendations on advance directives.

*2. Facing the Bind: Inside the Walls*
-The reality of asymmetrical power relations inside hospital walls.
-The consequences of rebellion.
-The administration of forced treatment. Extended leave.
-The successes and failures of the forced treatment approach.
-The fear of being in a new and restrictive environment.

*3. On the Outside: Managing a New Identity*
-The shame of having been a psychiatric patient (a personal account).

-Shame, isolation, sedation and poverty.

*4. Transcending Stigma: The Lucky Few*
-The return to productive life, work, love and hope for the few, premature retirement for most.

**Brenda LeFrançois.** Social Work, Laurentian University; Editor, Radical Psychology

*Power Relations and User Involvement in Child Psychiatry*

This paper is based on a study conducted at an adolescent psychiatric inpatient unit in the UK. The study involved engaging in ethnographic research with the aims of exploring relations of power, children's rights as well as patient perspectives of mental distress and psychiatric treatment. The findings demonstrate that the exercise of power is pervasive, multi-directional and productive within inpatient Child and Adolescent Mental Health Services (CAMHS). Moreover, despite showing a willingness and ability to be actively involved, the young people are faced with a paternalistic and authoritarian approach to treatment which is antithetical to the principles of user involvement and renders their direct and meaningful participation in their treatment and care, as well as service development, unlikely. Overall, the findings suggest that treatment and care is dominated by social control and is experienced, for the most part, as distressing by the young people.

**Chris Vogt.** Sociology and Anthropology, Simon Fraser University

*Why am I so Mad?*

A nine year journey through the psychiatric system and complex discursive formulations saw this researcher go from paralyzed 'patient' to dissatisfied 'consumer' to a new phase of anger/ disbelief in coming to terms with his 'survival' of the psychiatrization process. This paper combines auto-ethnography, to show the social processes and causes of one specific case of a mental health diagnosis, and an iterative process of research on the 'psychiatric survivor movement'. At once historical and current, this process fuses an awareness of past activism with current initiatives and orients the project itself as psychiatric survivor activism and identity politics in praxis.

# SESSION 8.
# *Making 'Mad' Laws II; Socio-legal Representations of Madness, Danger and Crime*

**Bernadette Dallaire.** Service social, Université Laval

## *"What to do with 'them' ?" Treatment, Control and Rehabilitation as Social "Solutions" with Regard to Mental Illness and the Mentally Ill*

This paper aims to contextualize the question of law-making in the broader phenomenon of how society reacts to mental illness. By using the "social reaction to norms violations" theme (a now classic concept in the sociology of deviance — see Scheff, 1999) as the main thread for our analysis, we will review the various "solutions" currently used to tackle the "problems" posed by the presence of persons labelled as mentally ill in our societies: these include treatment-control under civil commitment orders, but also more "inclusive" responses that are promoted and applied in current rehabilitation practices (normalization, social integration and social participation, among others). What does it mean to treat⁄control⁄normalize⁄integrate, when the recipient is considered partially incompetent and potentially dangerous (to self or others)? What are the expectations toward this recipient: to comply, to behave, to fit in? In exploring these questions, we will consider the actors, institutions and practices involved and, more fundamentally, the social representations underlying these forms of social responses.

**Bruce Arrigo.** Criminal Justice, University of North Carolina, Charlotte

## *Towards a Critical Penology of the Mentally Ill Offender: On Law, Ideology, and the Logic of Competency*

This paper examines the "competency" construct as appropriated in the U.S legal system and applied to determinations of trial fitness and death row execution. At issue here is the potential for furthering a critical theory of punishment for persons with psychiatric disorders. Relying on the model developed by Arrigo (2002), this paper demonstrates how the logic of the legal and psychiatric communities is situated in and dependent on a circumscribed discourse that privileges certain versions of truth, identity, meaning, and reality. At the same time, these linguistic parameters of sense-making invalidate and, consequently, reject alternative grammars that represent replacement ways of thinking and being. As a result, expressions of difference in thought and behavior are pathologized. The pathology of difference in the instance of mental health system users when conveyed unconsciously through the written word (case law) is a stand-in for the sign of punishment. Thus, this paper explains how the competency construct punishes the mentally ill offender first through discourse, subsequently legitimized through social effect.

**Gordon Warme.** Author, Psychiatrist, Psychotherapist, CAMH, University of Toronto

*How the Myth of Schizophrenia is Used to Confine the Mad Against Their Will*

The legal ground for removing the civil rights of the mad is narrow: they are to be judged a danger either to themselves or to others. But there is a hidden ground that influences those who sit on the panels who make such decisions: they are concerned that the mad person suffers from a disease, one that they don't know they have. Members of such panels also suspect that this disease can be treated. The disease idea leads compassionate people to make a mistake, to think that obligatory confinement or treatment is for the "person's own good," a dismal and legal error. The disease make has led to the development of legislation in many jurisdictions that permits doctors to treat people in the community against their will, the so-called Community Treatment Orders, a signal that the decision makers think that the mad suffer from a disease—for which there is no evidence. Even though the technical grounds for confinement are dangerousness, again and again decision makers lean toward confining people whose behaviour—if it suggests dangerousness at all—is only questionably so. The behaviour everyone worries about, although distressing to the families of the mad and to the public, is only odd and unconventional. Apart from being bewildering and puzzling for the rest of us, madness is just another way of life, as legitimate as being a psychiatrist, a fool, or a genius.

Although the ultimate ground society uses to confine the mad against their will is that he or she is a "danger to himself or others," such future behaviours cannot be predicted. Although I've practiced psychiatry for many decades, I can predict violent behaviour no better than can the man in the street. It's possible, of course, to construct probability tables, but such tables are useless when dealing with a real, live person, an individual. A probability table could be created for the possibility of me —or any human being — becoming violent, but it could never actually predict whether I would commit an offense. It's the peculiar habits of the mad that lead us astray, an intolerance they induce in us, our powerful disapproval of oddity or unconventionality. There are lots of dangerous people around, drinking drivers, for example, but we rarely take away their civil rights. Unlike the mad, they tend to look like us and talk like us, and are therefore treated as legitimate citizens. When they offend, drinking drivers are held responsible for what they do—a courtesy less likely to be extended to the mad.

**Arlie Loughnan.** Law, University of Sydney, NSW, Australia

*Reason, Responsibility and Judgment: Mental Incapacity Defences in Criminal Law*

This paper gives an overview of the historical development, construction and operation of mental incapacity defences in the criminal law of England and Wales. Mental incapacity defences are those defences to criminal offences that excuse (or partially excuse) a defendant on the basis of his or her 'abnormal' mental state at the time of the offence or the time of the trial. The mental incapacity defences available in England and Wales are insanity, unfitness to plead, infanticide, diminished responsibility, intoxication and automatism. I argue that mental incapacity defences provide an important insight into the modern conceptualization of criminal responsibility. Further, I argue that responsibility must be understood not only through the elite discourses of law and medicine and psychiatry, and their interaction, but also by taking into account lay understandings of 'insane' behaviour.

## SESSION 9.
## *Taking Recovery Seriously*

**Michael McCubbin.** Nursing Sciences, Université Laval; Quebec Health Research Fund Scholar

### *To Dynamically Integrate Power and Empowerment, Social Inclusion, and Recovery: A Systemic, Teleological Approach*

Reformers – prodded and encouraged by user advocates and activists – have brought to emerging community mental health systems new approaches as ostensible principles for practice, policy, and, to a much lesser degree, governance. These orientations – including social inclusion, empowerment and more recently "recovery", touch on different aspects of what makes a healthy and just social response to psychological distress. I will firstly contextualize *empowerment* in the emerging population health research showing the crucial role *power* plays in explaining the socioeconomic gradient with health. Oppression indeed creates sickness, whether physical or psychological. I will then describe the concept of *social inclusion* as I understand it and as a much better alternative to "social integration" and "normalization", both of which can imply "fitting into the mould". Finally, I will describe, in reference to my research projects, my understanding of recovery as emerging in large part from, and in mutual interaction with, empowerment, social inclusion and primordially, the evolving visions and aspirations of persons recovering – as such, in a *systemic, teleological* process. I hope this presentation will foster reflection and enthusiasm necessary to the advancement of these concepts which, when not operationalized, can be easily co-opted.

**Helen P. Hamer.** Nursing, University of Auckland, New Zealand

### *Mental Health Service Users as Citizens in a Recovery Paradigm: The Implications for Mental Health Nursing Practice*

This qualitative doctoral study aims to explore the journey towards citizenship and full participation in society for people who are recovering from serious mental illness, and the implications for mental health nursing practice. This study will generate knowledge about the understanding of full participation as citizens, and whether the current framework of recovery focused care in mental health services helps or hinders the journey towards citizenship.

Generally the elements of citizenship such as political, social, and ethical have been critiqued but less so the elements of intimate (or sexual) and biomedical citizenship, particularly for those recovering from mental illness. This paper hopes to contribute to the emerging understanding of madness, citizenship and social justice for service users by discussing the parallels with another historically marginalised group: gay and lesbian citizens. This paper will also discuss the emerging findings from interviews with service users, mental health nurses and key stakeholders in statutory agencies.

**Larry Green.** Faculty of Education and Institute for the Humanities, Simon Fraser University

*Trauma: The Emperor with no Clothes (What Trauma Reveals about Main Stream Culture)*

I'm interested not only in alternative ways of looking at trauma but also what is revealed when we look *from* trauma. The fundamental experience of trauma is the breakdown of the subject object boundary. This boundary establishes the primal categories from which all other categories are derived. Consequently its dissolution leaves the person feeling disorientated and terror stricken. It is not only the objective trauma that distresses but also the loss of integrity, coherence, agency, etc. These experiences put the person beyond the bounds of consensual reality … i.e. the person no longer operates on the same assumptions that unconsciously govern the behavior of the vast majority of the members of one's society or culture.

Perhaps you can see where I'm going with this. I'm saying that the typical theoretical discussion operates within the assumptions of consensual reality in order to "know" the traumatized individual. These assumptions are background, implicit and unconscious while the traumatized person is foregrounded, made explicit and "objectivized". I wonder if it is possible to reverse this point of view and make the culture the figure and the traumatized individual the benchmark. By so doing could the traumatized figure shed some light on the taken-for-granted but not so benevolent assumptions of the mainstream?

**Leon Redler.** Diorama Arts, London, England

*We All Go Astray*

Many of our culture's predominant institutions and laws are founded, at least in part, on the notion that it's just some of us that go astray, whether because of bad genes, bad morals, bad company or varieties of bad luck.

It seems to me that most of us, much of the time, go astray ... from an embodied knowing of who and how we inter-are.

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Just as our way of going astray is singular, so our way of finding our way needs to be singular.

I propose key elements of finding one's way, especially when quite distressed:

1. Auto-rhythmia
2. Unwinding
3. Releasing
4. Coming to one's senses
5. Enjoying
6. Dwelling and being with
7. Meeting oneself and others
8. Moving toward responsibility … responsible for the Other and others (Levinas)
9. And toward a justice to come (Derrida)
10. Whereby we might come to celebrate the sacrament of the present moment.

## SESSION 10.
## *Madness on the Streets, and in the Suites*

**Elizabeth Metcalf.** Disability Studies and Women's Studies, Syracuse University

### *The Revolving Door: Institutionalization After Deinstitutionalization*

Gone are the days where souls are lost to the back wards of public institutions for years on end. Institutionalization is not gone however. It has merely transformed its trickster identity into something more subtle yet equally as dangerous for one trapped in its new more cyclical and repetitive nature. In this paper, I explore the new institutionalization snare of our current era and the plight of those existing in the margin between inside and out, trapped within a long terms series of "revolving door" hospital short-stays, no sooner to return to geographies of exclusion to begin the cycle all over again. The new institutionalization is a more sophisticated and nuanced incarnation of the old one fashioned by an insurance industry that has wholeheartedly embraced the quick-fix biological trends in traditional psychiatry. This paper was born out of autoethnographic notes of a survivor/user stuck in the revolving door cycle of the new institutionalization for ten years and in-depth interviews with practitioners critical of the current state of affairs in American mental health care.

**Erick Fabris**. Sociology and Equity Studies in Education, Ontario Institute for Studies in Education, University of Toronto

*Poison or Prison? Your Choice: Community Treatment Orders as Chemical Incarceration in Ontario Psychiatric Survivor Experience*

This people's report on the status of CTOs in Ontario uses psychiatric practitioners reports on survivor experiences of CTOs to show that tranquilization (in the home or in a prison) are a preferred method of state custodialism: a chemical incarceration. CTOs show not only how coercions that exist informally (often in the form of 'therapeutic agreements') are legally coherent and documented, but also how the notion of psychiatric negotiation may include 'coercion' as one of many 'treatment modalities'. By 'choosing' a CTO in Ontario, for example, the industry hopes to show that coercion is a treatment amenable, even necessary, to good health. I will interrogate this idea of treatment-induced 'insight' as health rather than abeyance, and of the psychiatric industry's claim that 'insight' is a requirement for claiming constitutional rights.

**Lilith Finkler.** Disabilities Advocate; Trudeau Scholar; School of Planning, Law, Dalhousie University

*Psychiatric Survivor Human Rights at the Ontario Municipal Board (OMB)*

Ontario legislation prohibits discrimination on the basis of disability. Nonetheless, municipal officials continue to oppose housing for psychiatric survivors. Sometimes municipalities employ exclusionary zoning to stymie development. Cases originally heard before municipal committees are sometimes appealed to the Ontario Municipal Board, an administrative tribunal that renders decisions regarding land use disputes.

Efforts to directly challenge discriminatory zoning at the OMB have not been successful. Supreme Court decisions state that adjudicators can hear human rights arguments pertaining to matters under their jurisdiction, OMB members, however, do not believe they can do so. This discrepancy between perceived and real juridical authority makes it difficult to address human rights violations before the OMB. In addition, housing developers wish to contain legal costs and are reluctant to anger municipal funders. These factors compromise psychiatric survivor human rights in a land use law context.

**Amy Lynn Klassen.** Sociology, University of Alberta

*Do Albertans Socially Reject Psychiatric Patients and their Families?*

The stigma of mental illness is a public health concern that demands our attention because of the impact that psychiatric labels have on the lives of people with mental illness. I will be analyzing 12 questions from the 2007 Alberta Survey, a random sample of 1200 adult Albertans. My analysis will evaluate whether the desire for social distance (level of social rejection) from the mentally ill depends on the causal attributions for mental illness as well as the level of contact respondents have with psychiatric patients. The survey questions focused on how willing participants would be to interact with psychiatric patients and their family members in a variety of social situations as well as the endorsement of negative stereotypes associated with mental illness. The goals of my research are to explore the effects of social segregation based on mental health diagnoses and to identify some of the social conditions that stigma operates.

## SESSION 11.

## *Cultural Studies in Madness, Identity and Citizenship*

(Presented in collaboration with Gallery Gachet and the 2008 World Mad Pride Biennale, *One Flew West: Old Landmarks, New Topographies*)

**Tim Keane.** Comparative Literature Program, CUNY Graduate Center, New York, NY

*Out of Ward Seven and Into the Mirror City: Metaphors Beyond Normality in the Fiction of Janet Frame*

*Much madness is divinest sense…much sense the starkest madness*, Emily Dickinson famously wrote. Since Dickinson's time, Western creative artists have increasingly associated themselves with and/or been forcefully marginalized alongside the "mad." Yet post-structuralist thinkers (e.g., Michel Foucault, Jacques Derrida and Michel DeCerteau) emphasize how critical understanding of narrative, reading and "heterlogical" qualities of language reveals a coercive politics and a misguided normalizing of the written word. Beginning with a quick overview of traditional theories about metaphor as "aberrant," my talk focuses on the poetics of New Zealand novelist Janet Frame. Misdiagnosed as schizophrenic, Frame was incarcerated for seven years in mental institutions and saved from a leucotomy in part by the publication of her prize-winning book *The Lagoon* in 1951. Upon her release, and responding in part to her dehumanizing subjugation, Frame situated her fiction within the realist tradition in order to dismantle it. Her persistent use of poetry and metaphors to subvert linearity and sequence, her polysemous tropes of imagination and reality as "envoy" and "mirror city" in her memoir, and her allegorical re-readings of social institutions, manners and morality throughout her books represent one of the most thorough responses to the prevailing fictions of "normalcy" in the last fifty years. Citing representative texts, I will explore how Frame's prose celebrates the essentially "deviant" and "surreal" qualities of language in order to dramatize what she saw as the irrefutable madness of conventional daily life in the mid-to-late twentieth century.

**Tara Caffrey.** MSW Patient’s Rights Advocate, San Francisco, CA

## *We are still Mad about the Mad in San Francisco*

In November 2004, California voters passed Proposition 63, the law that would become the Mental Health Services Act. The Act was passed with a broad coalition of consumers, providers, and family members. Initially the passage was greeted with hope because the tax on millionaires that would fund programs promised a much needed infusion of cash into a system that many believe is broken and unable to serve the needs of California’s diverse population. Hope seems to be vanishing as California, through its counties, implements the Act. The Act promises to provide new, innovative and comprehensive programs to address the many needs of the “mentally ill,” with a focus on the voluntary treatment. Specifically, the funds were not to be used for involuntary treatment. Since the passage, some counties have asked for funds to provide involuntary hospitalization for up to 30 days.

The Act has been codified into the California Welfare and Institutions Code and the California Code of Regulations. The statute states that, “The state Department of Mental Health shall establish a program designed to prevent mental illness from becoming severe and disabling.” (WIC §5840 (a)) The statute goes on to say that, “The program shall include the following components: Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services and a Reduction in discrimination against people with mental illness.” (WIC §5840 (b) (3) (4) ) The new law seems to be trying to get individuals to seek help and treatment before they become so sick that they become a financial burden to themselves, their families and the counties they live in. But can a law change the stigmatizing impact of having a diagnosis? Can a law change the attitudes that services providers and the public have about people with a diagnosis? Can a law make ineffective treatment, effective?

The law and those who supported its passage and those who are working on its implementation all have the best of intentions. However, the reduction in stigma and discrimination is impossible when the public, providers included, believe in the efficacy and necessity of involuntary treatment for those with so called mental illness. The Act has not changed how treatment is conceived—the Act wants people to have access to treatment that is “medically necessary.” This paper is a textual analysis of San Francisco Chronicle columnist CW Nevius and how his work has helped perpetuate stigma and discrimination in San Francisco. Mental illness and homelessness is a political issue because of the unsightly nature of both. Public attitudes supporting involuntary treatment are reinforced by Nevius. The public is able to respond to his columns on the Chronicle’s website, sfgate.com. This paper will look at the columns and the comments to demonstrate that since the passage of the Mental Health Services Act, stigma and discrimination are alive and well in San Francisco. The stigma and discrimination move beyond those who have been diagnosed or the waiting/needing to be diagnosed to those who support and advocate for their right to treatment or their right to refuse treatment.

**Jiji Voronka.** Disability Studies, Ryerson University

*Bipolar Britney: Spear(s)heading Diagnosis Through Media Monitoring*

My talk will engage the ways in which "the madness of Britney Spears" is being taken up in various media (traditional "legitimate" news; tabloid press; and online blog and video streaming). Specifically, I will explore two competing approaches that have emerged during the documentation of Britney's "descent into madness":

1) The biomedical approach, in which Britney is understood as biologically mad (and diagnosed through media accounts as *suffering* from bi-polar/split personality/manic depression/post-partum depression/dissociative personality disorder/schizophrenia). This approach positions her as mentally ill, and the media is understood as simply a passive agent documenting her madness through storied accounts, photos and video.

2) The psychosocial approach to Britney's madness, which positions the traumas of the paparazzi, diet and beauty pressures, and the perils of Hollywood child-stars into a social causation model that faults Hollywood culture as the main cause of Britney's "demise."

In exploring the medical vs. social discourses that surround Britney's current state of mind, I want to examine how "understanding Britney" impacts our collective understanding of modern day madness, and enter into the debate that Britney's media case study creates: are we crazy? Is our modern day culture making us crazy? Or is the modern day crazy?

## SESSION 12.

## *Psychopolitics Reconsidered: Reflections on the Anti-Psychiatry Movement*

**Jerald Zaslove.** English and Humanities, Simon Fraser University

*Looking Backward – But How Far Backward? - A Personal View of the Origins of the Anti-institutional 'Sixties and their Aftermath ...*

"If you have understanding and a heart show only one. Both they will damn, if you show both together."

Friedrich Hölderlin & T.W. Adorno

One severely utopian movement in the so called counter cultural sixties was what I call," the use of the utopian will" to change the direction of institutions that had come under attack since the 1950s as willfully obtuse institutions – schooling, psychiatry, universities, the military-industrial complex and bureaucratic institutions. Hannah Arendt's Eichmann principle that challenged the very idea of citizenship, Bruno Bettelheim's work on autism and children, and his study "The Informed Heart", Norman O. Brown and Herbert Marcuse's pursuit of the "French Revolution", as well as R.D. Laing's work fed into what became a dimension of how the ordinary citizen might see mental illness. I will take a personal look at these powerful influences that affected the 'student' public sphere and eventually the fear of institutions. Into this mix came two films that not only fit the times but added a dimension that hitherto did not exist in the same way: Frederic Wiseman's *Titicut Follies* and Peter Weiss' *Marat/Sade – the persecution and assassination of Marat as performed by the inmates of the asylum of Charenton under the direction of the Marquis de Sade.* Both authors became in an ironic twist of fate "Marat-Sades" as their work was condemned. Why were we afraid of them?

**Gary McCarron.** Communication, Simon Fraser University

*'Talking it Through': Mental Illness and Emancipatory Discourse*

Communication has long been implicated in the popular conception of mental illness. From those who claim to hear voices to the fragmented "word salad" of the schizophrenic, communication skills and language competence are frequently among the primary markers by which mental health has been measured. This paper looks back to the days of Paul Watzlawick, Gregory Bateson, R. D. Laing and others in order to recuperate the spirit of a mode of theorizing that recognized the centrality of communication patterns in the formation and presentation of mental illness, a way of conceptualizing those afflicted with emotional distress that sought to understand their plight rather than to merely explain it (Dilthey). My intention is not to romanticize a historical period when mental illness was theorized as a form of communicational pathology, but to see the prospects for emotional emancipation and psychological wellbeing embedded in these more discursive approaches to mental illness. I want to suggest that the prospect for social justice for the mentally ill was greater when their humanity was confirmed in forms of therapy that focused on communication as opposed to the modern tendency to dampen affect and manage behavioral problems with drugs. I would never deny the usefulness of pharmaceuticals (though I would be inclined at times to condemn them, ironically, for working too well), but I think that the cultural ethos that reigns in our "pharmatropia" is part of Deleuze's control society in the worse sense possible.

**Andrea White.** Social Work, York University

*A Patient Rereading of the Italian Psychiatric Reform: Franco Basaglia and the Therapeutic Community at Gorizia*

This essay examines the period of psychiatric reform in Italy that took place at the manicomo (asylum) at Gorizia, Italy, under the direction of the nonconformist psychiatrist, Franco Basaglia (1924-1980) from 1961-1968 who worked to restructure the Italian mental health system. His efforts culminated in the passing of Law 180 in 1978 which dramatically altered mental health services in Italy. Through an examination of some of the available literature in English and French on the remarkable transformation from "total institution" to an open therapeutic community, I explore how the Italian psychiatric reform project has been represented in various contexts. I attempt to bring some of the deinstitutionalized inmate cum patient experiences of the reform to the surface by unearthing some of the silences and illuminating some of the erasures of patient narratives excluded from the current historical, psychiatric and anthropological record on the subject.

**Richard A. Ingram.** Ryerson-RBC Institute for Disability Studies Research and Education, Ryerson University

*Madness and Political Strategy: Capitalism and Schizophrenia Revisited*

In their two-volume study, *Capitalism and Schizophrenia*, Gilles Deleuze and Félix Guattari sought to salvage what was still vital from the Marxist and Freudian traditions, while thoroughly rethinking social and political theory and practice. This undertaking entailed an engagement with madness that went well beyond any attempt to integrate alternative perspectives within an expanded rationalism. Their willingness to take madness seriously marked a break with left-wing projects based on a rational reconstruction of the social, while also running the risk of appropriating the insights of psychiatrized people. My presentation will contend that the breakthroughs of *Anti-Oedipus* and *A Thousand Plateaus* remain largely unsurpassed, and will focus on relating the concepts of *Capitalism and Schizophrenia* (desire, production, rhizomes, schizoanalysis, intensities) to the themes of "madness, citizenship and social justice."

## SESSION 13.
## *After the Kirby Report: A Critical Dialogue*

**Kimberley White.** Law and Society Program, York University

*Out of the Shadows and Into the Spotlight: The Politics of (In)visibility and the Implementation of the Mental Health Commission of Canada*

The creation of the Mental Health Commission of Canada (MHCC) was first proposed by the Standing Senate Committee in November 2005, and was reaffirmed in May 2006, when the Committee tabled its final report titled, *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Also known as the Kirby Report). One of the "key initiatives" that has been established as a priority for the new MHCC is the development of a national “anti-stigma campaign” aimed at promoting better understanding of “mental illness” among the general population, diminishing discrimination, and changing public attitudes toward mental illness. At the same time, the Commission has set a general, and on the surface quite progressive, goal to place “individuals living with mental illness” at the “centre” of all its work. But what does this mean?

My research in general is to document the on-the-ground work of the Commission over its formative years, and to place both the Commission as an organization and its work on “transforming” public perception and mental health services in Canada, into a broader social, historical, and political context. In this paper I will focus on the issues currently arising from the Commission’s efforts to bring mental illness, and those living with mental illness, into the public spotlight. I draw particular attention to how various form of knowledge about mental illness are ordered and operationalized in the aim to educate the public and “erase” stigma, and to the politics of (in)visibility that will necessarily inform these official representations.

**Rob Wipond.** Freelance Writer, Victoria, BC

*A “Patient-Centred” Way towards Ignoring Patient Rights -- The Kirby Report’s Dismissal of Legal Concerns and Psychiatric Survivor Perspectives*

In 2004, the Federal Senate Committee on Mental Health was tasked with crossing the country to hear and consider as wide a range of perspectives as possible on the state of Canada’s mental health system and about possible avenues for improving it.

However, the three background documents the committee released as a starting point for public discussions were already heavily steeped in the language and conceptual frameworks of the biomedical model of mental illness and forcible psychiatric intervention. The documents also already contained many implicit and explicit attacks on perspectives that were critical of that model.

While making a presentation to the Committee alongside a psychiatric survivor, journalist Rob Wipond found that the committee did not show a willingness to seriously consider civil rights concerns or alternatives to forced psychiatric intervention.

A preliminary analysis of the Senate Committee’s public feedback shows a substantial disjuncture between the positions expressed regarding civil rights concerns and the problems with forced psychiatric interventions from consumers and survivors, and the extremely limited discussion of these topics in the Committee’s final report.

**Jennifer M. Kilty.** Criminology, University of Ottawa
**Colleen Dell.** Sociology, University of Saskatchewan
**Sharon Acoose.** Indian Social Work, First Nations University of Canada
**Debbie Blunderfield.** Community Participant, Saskatoon, Saskatchewan
**Val Desjarlais.** Community Participant, Saskatoon, Saskatchewan

### *Positioning the Voices of First Nations Women: The Impact of Stigma in Our Healing Journeys from Illicit Drug Abuse*

Within his report, Senator Michael Kirby identifies that he has failed to address substance abuse in appropriate depth. He also acknowledges that, "the addiction field lacks powerful voices, a vacuum that has left only policy makers and health providers to speak for anonymous clients" (p.207). The report's lack of representation of the voices, standpoints and discourses of individuals dealing with addictions is reflective of the field in general. The need to address this shortcoming is particularly evident in Kirby's discussion of stigma and addictions in his report.

This paper discusses how the voices of First Nations women are directing a national research project on the role of stigma in their healing journeys from illicit drug abuse. What may appear on its surface to be a simple objective is in fact an intense and complex undertaking. For example, our project began with compiling the life histories of three First Nations team members regarding their personal healing journeys from illicit drug abuse, with each reflecting on the important role of self-identity and the devastating impacts of stigma on the construction of their sense of self. Although antithetical to a western approach to understanding, it was the only way we could responsibly commence a 3-year study that was committed to positioning the experiences of women so that their voices are authoritative, recognized and celebrated. This paper raises key insights from our research experiences that we suggest must be considered if meaningful discussion is going to ensue from the Kirby report regarding addictions and hearing the voices of those most impacted.

**Geertje Boschma and Vicki Smye.** Nursing, University of British Columbia

### *Diversity of Voices: Will it Make a Difference?*

In response to the Kirby report, the Mental Health Commission of Canada was established in the summer of 2007, chaired by Senator Kirby. One of the goals of the Commission is to "[b]e a catalyst for the reform of mental health policies and improvements in service delivery." The committee members are a diverse group of Canadians representing a wide range of stakeholder's voices in mental health.

The purpose of our presentation on this panel is to raise further discussion about the opportunities and challenges related to this particular goal. We perceive the inclusion of diverse voices as an opportunity for being a change catalyst, but it also poses challenges.

We ask, who do we listen to and what do we draw from what we hear? The inclusion of diverse voices does not automatically translate into change. If not hand in hand with political good will, voice may be silenced. We present findings from our research on both historical and current experiences of people accessing mental health and addiction services to critique this issue.

## SESSION 14.
## *Pictures of Self-Harm*

**Edith Regier and Tonya Tabobondung..** The Crossing Communities Art Project, Winnipeg, MB
**Cathy Fillmore.** Sociology, University of Winnipeg

*Pictures of Self-Harm*

We propose to present the short film "Pictures of Self-Harm" as part of Crossing Community Art Project's ten-year history of investigating art as social change.

Pictures of Self-Harm, 2007 (23 minutes) was produced out of a five year project where marginalized women portray and reflect on their drug addictions, cutting, the sex trade/sexual exploitation, and eating disorders. As authors, interviewers and directors of the film, they present an unblinking look at self-harm and conduct street interviews about perceptions of self-harm and its place in our society. The project began with the initial question "if art is a language and self-harm is a language are the two interchangeable".

We will screen "Pictures of Self-Harm" and initiate a community conversation on self-harm led by one of the women in the film, Tonya Tabobondung, along with Edith Regier, MFA, Artistic Director of the project, and sociologist, Dr. Cathy Fillmore.

## SESSION 15.
## *Governing Mentalities in the Pacific Northwest*

**Kathryn McKay.** History, Simon Fraser University

*Before the Cuckoo's Nest: Madness and Traditional Healing in the Ethnographic Record*

My paper will examine the intersection of colonialism and madness in the depiction of First Nation peoples in British Columbia. A number of factors, both international and regional, influenced the historical context of this experience. At the same time that colonization was driving the resettlement of BC, the discipline of psychiatry was achieving respectability and prominence; “sciences,” such as craniometry, were used to explain the perceived differences between the races. The importance of mental hygiene as a social issue was such that the construction of a mental hospital was part of the inducements offered to the province to join Confederation. The records from this hospital system indicate that western definitions of mental health/ illness were imposed upon First Nation peoples. Diagnoses made by doctors who had little or no cultural understanding of First Nations patients resulted in long standing stereotypes. These stereotypes have remained despite psychiatry’s shifting trends over the last 130 years. Other factors, such as criminality and changing social mores, have also influenced the perception of mental health/illness in colonized populations.

**Arthur Allen.** Architect, Author, West Vancouver, BC

*Architectural Function and the Early Mental Hospitals of Western Canada*

From 1878 to 1923 the four western provinces of Canada constructed 8 mental hospitals, 2 in each province. The plans and designs of those buildings will be shown by 35 mm slides. The architecture of the buildings will be considered from comments by psychiatrists, administrators, staff, inspectors, architects and public observers. Commentary by former psychiatric patients in Western Canada is rare, but numerous autobiographies by patients from other hospitals will be introduced to the discussion. Relevant scholarly findings from the architectural history of mental hospitals will be included. Emphasis will be placed on the perceptions of patients, and the value of behavioural research to architectural ethics and practice. The functionality and ethical background of buildings for confinement will receive special attention.

**Andrea Kovalesky.** Nursing, University of Washington, Bothell

*Factors Influencing the Role of Nurses in Washington State Over the Last 40 Years Towards Persons with Serious Mental Illness*

Over the last 40 years both the treatment of persons with serious mental illnesses (SMI) and the role of nurses in general have changed profoundly. In this presentation I describe the more dynamic of these changes, using materials from various archives and library systems within Washington State, to posit some of the factors that have influenced the nursing profession in trying to promote social justice for persons with SMI. Besides the more obvious changes of the healthcare system in general, gender roles, and the process of deinstitutionalization, some other factors include changes in nursing education and nurse practice acts and national and state legislation promoting incarceration for drug and alcohol crimes; none of these factors stand alone but rather intersect in a variety of ways.

**Seantel Anaïs.** Sociology, Memorial University of Newfoundland

### *State of Terminal Exception: Biopolitics, Bare Life and the State of Exception at Vancouver International Airport*

The article explores the strong intersection between police use of force, the biopolitical nature of modern rule, and security networks ostensibly charged with meeting defense needs in a "post 9/11 world". An analysis of Giorgio Agamben's discussion of "bare life" and "states of exception"provide the framework within which a recent death-in-custody at the Vancouver International Airport is examined for its biopolitical character. Building on Agamben's extension of Michel Foucault's intellection of modern biopolitics, the article considers the ways in which the camp is maintained, reproduced, and disseminated throughout "secure areas" post-9/11. The article shows that the cascade of events leading up to Robert Dziekanski's death in the secure area of the Vancouver International arrivals terminal resonates with Agamben's representation of modern rule so faithfully that public or official reaction proportional to the injustice that it addresses is unlikely if not impossible. Echoing Agamben's discussion of the concentration camp, the article asks not how the use of police force led to death in this case, but rather, what juridical apparatus allows all who enter secure areas (such as the air terminal) to be stripped of their human rights? In particular, this article considers Dziekanski's perceived state of agitation, or madness, to be a dominant factor in the biopolitical nature of his exchange with police. The spatial/physical features of the secure international arrival area of the Vancouver International Airport, where Robert Dziekanski languished for ten hours before his altercation with police, are discussed with reference to their adherence (whether intentional or not) to a program of sensory deprivation. Additionally, Dziekanski's movements within overlapping 'territories of exception': those that have emerged as "secure" environments post-9/11, and those that emerge in the apparently discomposed mind, are considered. The article sees Dziekanski's presence within these overlapping spaces of exception as the ultimate rational behind his deadly exchange with police, who make sovereign decisions on the bare life of subjects in mere moments.

## SESSION 16.
## *Contesting Sanism 1: Political Strategizing for the 21st Century*

**Jeffrey Shantz.** Criminology Department, Kwantlen Polytechnic University

### *Madness, Anarchy: Autonomous Organizing, Self-Determination and the Coming Communities*

The paper draws on theories of new social movements and new theories of citizenship to identify and discuss issues that emerge as central for understanding the significance of

self-organization among psychiatric survivor groups. Discussion is also given to intersections of psyc survivor movements and anarchist politics. Such self-organizing movements break with the *habitus* of representative, hierarchical, politics suggesting alternatives based in mutual aid (Kropotkin).

Efforts by people to define themselves, rather than submit to a definition imposed by welfare and other state professionals, include such diverse practices as direct action and alternative art or activist sociology. Many contemporary movements deploy forms of counter-science, alternative practices for alternative forms and objects of knowledge or expertise. Movements open up new spaces for knowledge production and allow for a body of counter-discourses to develop. These spaces, what Foucault terms heterotopias, are the “experiments in practice” for the coming communities (Agamben), the “citizens without citizenship.”

Some argue that agency is the defining characteristic of citizenship as citizens, more than simply being members of the worlds in which they live, are makers and creators. Citizenship is not about having certain rights or responsibilities, but about being able to participate in the community. The concept of citizenship is not only political, but also sociological. The emphasis is not upon representation or inclusion (since the question is not one of exclusion but the conditions of inclusion) but upon attempts to develop self-determination and autonomy.

**Lydia Lewis.** Sociology, University of Warwick, Coventry, England

*Mental Health and Human Rights: A Common Agenda for User/Survivor and Women’s Groups?*

In the UK, the formation of a new Equalities and Human Rights Commission is reinvigorating debates about mental health and human rights. Working across a variety of inequalities strands, its mental health agenda provides an important opportunity for coalescing the work of mental health service user/survivor and women’s groups. In this context, this paper examines the relationship between these groups, which has been marked by both convergence and contestation. Drawing on a study of mental health service user/community groups in one locality, it explores some of the ideological and identity issues which require working through in order to achieve a common agenda for change. The paper concludes with implications for future organising relating to: developing a consensual social model of distress; the medicalisation of violence; combating stigma and deauthorisation; and recognising common and differentiated identities and experiences.

**Maria Liegghio and Shoshana Pollack.** Social Work, Wilfrid Laurier University

*Conversations with a Criminalized Mind*

The focus of this paper is on the conversations that occur when the *'madman'* chooses to intersect and interact with the criminal justice system. In an eight month period, my brother, a graduate student in inorganic chemistry, setup a 200-plant, marijuana grow operation. His intention was to donate the proceeds to charities working for the rights of those most marginalised and oppressed within society. A week before cultivation, he turned himself into police. Structured in three parts, the paper presents conversations leading up to, during, and after contact was made with the criminal justice system. The first part explores conversations about the making of a mad mind versus the making of a criminal mind. The second part discusses the similar and competing interests of madness and criminality within society, and the third part explores the silenced and oppressed interests of the persons (brother/sister) at the borderlands between madness and criminality.

## SESSION 17.
## *Neither Bad nor Mad … But Getting Angry! (Panel)*

**Kim Pate.** Canadian Association of Elizabeth Fry Societies
**Debbie Kilroy.** Sisters Inside, Brisbane, Australia
**Lisa Neve.** Canadian Association of Elizabeth Fry Societies
**Christine Lamont.** Strength in Sisterhood, Vancouver

The panel will identify the range of issues in Canada, Australia and other jurisdictions, associated with the increased marginalization, victimization, criminalization and institutionalization of women and girls. with a particular focus on the psy-ing of women and the nature and impact of the use of solitary confinement as a penal response.

## SESSION 18.
## *The Politics of Diagnosis I*

**Stuart A. Kirk.** Social Welfare, University of California, Los Angeles

*From Freud's Science of Dreams to the DSM's Dreams of Science*

Using intensive case analysis, Freud argued that patients' dreams could yield an understanding of the causes and mechanisms of psychopathology. Freud's science of dreams spawned a revolution in the study and treatment of mental illness during the first half of the 20th Century. Another psychiatric revolution was announced in 1980, with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). DSM-III, not only marked the end of the dominance of Freudian thought, but also replaced Freud's science of dreams with a Neo-Kraepelinian attempt at making psychiatric diagnosis scientific. DSM-III's dreams of science involved the creation and use of diagnostic checklists, structured interviews, and other research techniques. Since 1980, advertisements for all new editions of DSM claim that the dream of scientific diagnoses has become a reality. This paper will argue that these key claims made for DSM are often the product of illusions, not those of patients, as Freud used, but those of psychiatrists who developed and promoted the new manuals. The paper will examine three of DSM's dreams of science: that DSM identifies mental disorders validly; that diagnoses can be made reliably, and that clinicians use DSM appropriately.

**Gordon Warme.** Author, Psychiatrist, Psychotherapist, CAMH, University of Toronto

*The Eternal Illusion: A Brief History of Psychiatric Causality*

I'll first make a few comments about the DSM project and why it is so important for psychiatrists. The rationale for the DSM classification system is that it is purely descriptive, and that sticking to such a predetermined naming of syndromes will then lead to reliable research. The problem with this argument is that it presupposes that there is a disease there to be discovered. In other words, instead of discovering a disease and then pinning down how it can be identified, psychiatry has turned our usual medical methods upside down: looking for a cause before a disease has been discovered. I'll also make brief comments about the total lack of evidence that there is anything biologically wrong with the mad. Instead of giving us real evidence, investigators predict that evidence will soon be found, that "evidence is converging," or that there is "suggestive evidence." This violates every scientific rule. It's a bit like saying that they hope soon to find a cancer cell in a patient in whom there is no evidence of cancer. It's often said that "some" of the people diagnosed as schizophrenic show changes in their frontal lobes. They might as well say that some people diagnosed as schizophrenic have moles on their back: the statement proves nothing. It's a bit like saying that some patients have cancer cells in their bodies, but some don't. To be a scientific statement, the so-called abnormality must be present every time.

Madness has always led observers to invent "causes," an obsessive quest that depends on the idea that there is a disease or ailment for which a cause has to be found. The faultiness of that quest is best illustrated by the common complaint of the mad that their brains have been injured, affected, or influenced by some chemical, radiation, or x-ray, to which psychiatrists react by arguing that these people have such thoughts because their brain has been influenced by some chemical, radiation, or x-ray. A few hundred years ago, the mad claimed that demons or witches possessed and influenced them, to which priests responded by saying that they had such thoughts because demons and witches had possessed and influenced them. I have many such examples of the circular thinking indulged in by observers of mad behaviour.

**Greg Bowden.** Sociology, University of Alberta

*Attention Deficit Hyperactivity Disorder: What is the Meaning of Self-Control?*

Contemporary theories of Attention-Deficit Hyperactivity Disorder (ADHD) characterize the disorder as a problem of self-control, where the individual with ADHD has difficulty initiating and inhibiting action. This understanding has pragmatic value for the treatment of the disorder. However, ‘self-control’ occurs at the intersection of individual action and social order, and we understand it only in a context of a shared world and social norms. In this sense, governance of one’s self, which is ostensibly one mode of autonomy, acts in tandem with adherence to institutionalized demands for social order. In this paper I ask whether we should read interventions intended to restore ‘self-control’ to individuals with ADHD as solely emancipatory or solely determining or constraining. Such readings culiminate in contradictions around both the understanding of ADHD and the understanding of forms of control and autonomy in general.

## SESSION 19.
## *Contesting Sanism II: The Psychiatric Survivor as Active Citizen*

**Rob Wipond.** Freelance Writer, Victoria, BC

*News Media and the Psychiatric Survivor Perspective*

The “pitch” is a brief oral summary or carefully-structured half-page written outline of a news story idea. The pitch is the primary basis for decision-making by editors and producers about what gets into the news and what doesn’t.

Trying to pitch stories to news media editors and producers about mental health issues from the perspective of psychiatric survivors and civil rights presents unique, sometimes almost insurmountable challenges. The journalist must typically negotiate many layers of assumptions, complex sets of beliefs, and numerous practical problems before even the basics of the story idea can be effectively conveyed to the editor or producer.

In this session, professional journalist and University of Victoria writing sessional Rob Wipond will outline the basics of a strong hard news or news feature pitch, and examine the reasons why this professional standard makes getting the perspectives of psychiatric survivors into our news media so difficult.

**Kathleen Sumilas.** Advocate/Activist, Victoria, BC

*My Experience as a First Time Advocate/Activist*

I was thrust into becoming an advocate/activist as a user of the mental health system when it was announced on May 30, 2007 that Laurel House, an activity centre for the mentally ill in Victoria, BC, was going to be closed on September 30, 2007. I will share with you all my first-time experiences of how I survived the stress, and the huge learning curve that I had to deal with on a rigid time-line. Most of all, I will share with you the positive impact it has had on my life, and those for whom I was helping to advocate, who are being greatly affected by the outcome of the Laurel House struggle with the Vancouver Island Health Authority (VIHA) and the Capital Mental Health Association.

**J.T. Sandhu, AKA Ruby Diamond.** Activist and Author, Vancouver, BC

*The Dignity of the Mad*

My paper wishes to expose the present day consensus that all mental illnesses have their root in biochemical deformity as both dangerous and misguided. This paradigm allows for the dismissal of psycho-spiritual crisis as being influenced by societal and family dysfunction. It allows for the victim of trauma or other emotional distress as having defective genes and then completely justifies and ignores his or her social context. While schizophrenia may be based in a chemical imbalance, not all mental illnesses have their root in biological deformity.

If schizophrenia is due to a biochemical imbalance, which it may indeed be, why is it we are rarely treated with empathy and respect the same way a cancer patient would be treated? We must understand the language of the mentally ill person by engaging in that person’s world view and by understanding the context and personal history of that person.

Some of us are labelled mad because we do not conform to what is real crazymaking. Systemic racism, sexism, poverty and homophobia are true crazy making. However, these ideologies are ignored and not understood or explained by most mental health professionals further contributing to being a sick society. In fact marginalized groups who seek out or by force are introduced to the mental health system are often misunderstood, cannot voice their opinion safely, face a lack of empathy and understanding for their emotional turmoil caused by their status of being marginalized members of society. Instead of gaining understanding they are further stigmatized by the label of mental illness and retraumatized by the practices of electro-shock therapy, forced medication and confinement. The history of the asylum and its practices are steeped in human rights violations. This is the legacy and historical context within which the present day mental health farms operate. Just as we cannot ignore the social and historical context of slavery within which African American experience is based, so we cannot forget that the madhouse of the past has influenced the psychiatric institutions of today.

## SESSION 20.
## *Neither Bad nor Mad … But Getting Angry!* (Workshop)

**Kim Pate.** Canadian Association of Elizabeth Fry Societies
**Debbie Kilroy.** Sisters Inside, Brisbane, Australia
**Lisa Neve.** Canadian Association of Elizabeth Fry Societies
**Christine Lamont.** Strength in Sisterhood, Vancouver

The team will discuss the manner in which they have invoked human rights law and strategies in Canada and Australia, as well as the alliances that are being built globally to develop 'Human Rights in Action' initiatives with and by women in and from prison.

## SESSION 21.
## *The Politics of Diagnosis II*

**Norbert Andersch.** Maudsley Hospital (SlaM), London, England
**David Barfi.** Maudsley, Hospital, London, England.

*A Psychopathological Revolution: The 'Matrix-Model'*

*Purpose*: In the mid 19th century 'Euclidian Geometry', which over centuries was regarded as the natural and final stage of its discipline found itself replaced by a whole group of virtual and previously unimaginable spheres: the 'Riemann Geometries'. Only this radical paradigm shift from the obviousness of everyday practice into the abstract worlds of relational and symbolic order allowed Einstein's and Maxwell's theories to emerge and modern mathematics to be developed. Psychopathology is in urgent need of a comparable turn - beyond the narrow field of clinical observation towards a theory of 'mental formation' - to conceptualize the underlying structural order from which a concept of mental illness can be deducted.

*Method*: The presentation reconstructs an interdisciplinary theoretical network including Arthur Kronfeld, Kurt Goldstein, Kurt Lewin and Gestalttherapists - all of them relocating the focus of psychopathological observation away from the brain to the inner tension and relational order between individual and environment/social field. This cooperation towards a 'New Psychopathology' never entered mainstream psychiatry as all its stakeholders were driven into exile from Nazi-Germany. They all had been influenced by Ernst Cassirer's "Philosophy of Symbolic Forms", applying the ideas of constant change in mathematical perspectives and mental complexity to cultural development - and its pathological disorders.

*Results*: 'Symbolic Forms' which emerge as magic, myth, language, religion, law, politics, science, the arts and others are transcultural universal phenomena and can be seen as 'invariants' in a 'Matrix of Mental Formation'. This artificial construct of culture breaks down in mental crisis.

*Conclusion*: Psychiatric illness is always connected to a breakdown of 'Symbolic Formation'. Its typical symptoms are not a lack of organic functioning - but derive from an inability to manage its complex 'meanings' in the constant change of parallel frames of reference. A structural concept (Matrix) of underlying relational order to change psychopathological classification is presented.

**Christina Martens.** Human and Social Development, University of Victoria

*Performing Borderline, Performing Bi-polar: Theorizing a Politics of Distress*

It is undeniable that people experience distress. How both the nature of the distress and the experience of it come to be understood is contingent on multiple factors including: social, cultural, economic, gender, and spatial conditions of the time in which it is theorized. Also important in how we understand distress are particular ontological and epistemological assumptions that are inherent in discourses on health and citizenship. Particular discourses, practices and technologies that support and naturalize particular meanings of distress shift through time and place, acquiring and losing meaning. Distress has come to be understood, since at least the 19th century, through the ever more specific discourses of psychiatric disorder and illness. While many conceptualizations of distress have been investigated (see eg. Micale 1995; Hacking 1995; Figert 1995; Stoppard 2000; Gremillion 2003; and Davidson 2003), the purpose of this paper is to extrapolate a politics of distress that identifies particular performances as Bi-polar disorder or Borderline personality disorder.

**Rebecca Godderis.** Sociology, University of Calgary

*Risky Moms: Psychiatric Discourse about Postpartum Depression*

Over the past ten years, the condition known as postpartum depression (PPD) has received a great deal of attention in the mental health literature. Studies have focused on demonstrating the link between maternal depression and an increase in a child's risk of mental health and social problems, including depression, anxiety, conduct disorder, and other developmental issues. Although there appears to be consensus about the harm PPD can cause to children and families, psychiatric researchers have yet to clearly isolate the cause or establish the standard characteristics of this condition. This ambiguity is reflected in the disagreement between the current DSM classification of PPD as a specifier with an onset of 4 weeks after parturition, compared to the research literature that often speaks of PPD as a distinct disorder occurring within 3-12 months after childbirth. Using theoretical insights from Foucault, science and technology studies, and feminism, I am mapping the emergence of PPD-related psychiatric discourse, including how the DSM-IV classification of postpartum onset was established. This paper will bring together initial findings from interviews with prominent PPD researchers, archival data, and published psychiatric literature to discuss the classification of postpartum psychiatric problems and how psychiatric debates have employed risk discourses and gendered assumptions about parenting.

**Maria Liegghio.** Social Work, Wilfrid Laurier University

*Madness Never Dies: Death, Dying, and Bereavement Under the DSM*

This paper explores the ways the DSM governs death, dying, and bereavement. Examples from my subjective experiences demonstrate the ways the DSM denies people's human rights, humanity, and dignity while dying and at death. In my mother's situation, the DSM and her diagnosis of manic depression shadowed her dying and the home palliative care services provided to her for cancer. At the moment my mother's symptoms shifted from physical to mental confusion and increased irritability, the in home care was removed citing policies about worker safety against perceptions about my mother's dangerousness. At the time of my brother's sudden death, the DSM was also evoked to address questions about whether or not his death confirmed the presence of a mental disorder. Under the DSM, my mother and brother were denied the dignity and humanity of dying with sanity, while my own grief and bereavement are overpowered by notions that madness never dies.

## SESSION 22.
## *End Electroshock Now: Contemporary Resistance Against Electroshock in Canada*

**Don Weitz.** Antipsychiatry Activist, Coalition Against Psychiatric Assault
**Shaindl Diamond.** Psychology, University of Toronto & Coalition Against Psychiatric Assault.

*Part I. Educating and Organizing*
Drawing from empirical research and psychiatric survivor narratives, this workshop will provide information about the effects of electroshock therapy. The video, *Electroshock is Not a Healing Option*, will be shown. It features personal testimonies about electroshock from *Inquiry into Psychiatry*, the public hearings hosted by the Coalition Against Psychiatric Assault at Toronto City Hall in April 2005. The presenters will also discuss

the context of historical and contemporary movements against electroshock with a particular focus on anti-shock resistance in Canada.

*Part II. Stop Shocking Our Mothers and Grandmothers! Antipsychiatry Perspectives on a Feminist Anti-Shock Campaign*
On Mother's Day 2007, in Toronto, the Coalition Against Psychiatric Assault (CAPA) organized a public, arts-based demonstration against electroshock therapy, specifically for its use on women. The presenters will explain why anti-psychiatry activists are framing electroshock as a feminist issue and discuss strategies used in planning the demonstration. Video footage and photographs taken at the demonstration will be shown to provide examples of how art was used to support the campaign message. There will also be discussion about future directions for feminist organizing against electroshock and how anti-psychiatry, psychiatric survivor, and other social justice organizations can support this campaign in their local contexts.

## SESSION 23.

## *Trends in the Treatment and Governance of Psychiatric Afflictions in the Criminal Justice System*

**Christie Barron.** Sociology, University of Calgary

### *Rehabilitating Violent Girls in the Age of Risk*

In this paper I analyze the various ways risk governance has impacted the rehabilitation and treatment of the young violent girl. Drawing on interview and file data collected in three youth custody centres, I question the meaning of rehabilitation as reflected in the treatment models used for the 'highest risk' girls both inside and outside the institution. For example, I consider how risk governance has complicated traditional 'psy' diagnoses. In addition to cognitive skills and anger management programs, which teach the girls to restructure their modes of thought, trauma counseling is presented as taking place through a therapeutic alliance between the psychologist and the young woman. However, as the stories from the young women reveal, a relation of trust cannot be established when the psychologist is evaluating the girls' traumatic experiences in terms of risk. The girls point out that their disclosure may elevate their level of risk which has detrimental consequences in either their custody or community case plan. Moreover, for girls who are deemed unmanageable in the institution, there are "behaviour modification" treatment measures which include inhumane amounts of isolation. Overall, it is the contention of this paper that once incarcerated, young female offenders convicted of a violent offence are placed *at risk* through the effects of current treatment practices.

**Michael Gulayets.** Sociology, Grant MacEwan College, Edmonton, AB.

### *Everyday Forms of Resistance in a Forensic Psychiatric Outpatient Clinic*

Individuals found 'Not Criminally Responsible on Account of Mental Disorder' (NCR) face powerful and established legal and psychiatric forms of regulation. This suggests a considerable imbalance of power between the individual and these institutions. But closer inspection often reveals subtle instances of resistance. This presentation explores acts of resistance undertaken by individuals found NCR within a forensic psychiatric outpatient clinic. Through the analysis of interactions between individuals found NCR and psychiatric professionals, this research finds that resistance in this setting does not take the form of organized or collective movements, but rather what may be called 'everyday forms of resistance'. The presentation examines examples of everyday forms of resistance focusing on both the tactics and targets of resistance. The analysis reveals that, in order to be discharged from their legal obligations, individuals found NCR must strike a balance between resisting psychiatric expertise and practices and exhibiting responsible behaviour – what I term 'responsibilised resistance'. The presentation concludes with the implications of resistance within this setting.

**Kathleen Kendall.** School of Medicine, University of Southhampton
**Dorothy Proctor.** Activist and Author, Toronto, ON

### *Testing the Limits of Justice: Human Experimentation in Canadian Prisons I*

In this presentation we critically examine human experimentation conducted in Canadian prisons during the second half of the twentieth century. Drawing on archival research, legal documentation, interviews and first-hand accounts, we argue that human experimentation upon incarcerated populations was at the nexus of three key factors: strategies to manage risk, psy-science technologies and corporate interests. 'Therapeutic' experimentation was legitimated on the grounds that it helped to discover the cause and cure of criminality and mental illness. These studies included the administration of painful electric shocks, sensory deprivation, LSD and other drugs. 'Non-therapeutic' experiments were carried out in conjunction with pharmaceutical companies and other big businesses. In these trials, prisoners were used to test such products as vitamins, aspirins, antibiotics, enema packs, food additives and pesticides. Finally, experiments designed to improve methods of 'prison management' employed solitary confinement and sensory deprivation. We will conclude with a consideration of how this experimentation has informed current practices.

**Dawn Moore and Erin Donohue.** Law, Carlton, University

*Consuming Justice: When Criminal Offenders become Pathological Clients*

In this paper, we are keen to have a look at a character who, while not new to criminal justice, has nonetheless taken on a new form: the criminal client. We are interested in this creature because her existence is not a mere convenience of correctional/therapeutic speak. Instead, she flags the confluence of these two areas of thought, risk and consumption. Our goal in this paper then is to use this figure as a means to understand how consumerism and risk overlie each other as a means of shaping a particular penal strategy and constituting the criminal/consumer through pathological identities. We suggest that the client at the crossroads of risk and consumption is a unique kind of character, suffering particular pathologies and, as a result, able to weather political climes that may otherwise prove inhospitable to therapeutic enterprises. In short, it is our assertion that the risky client is a particular manifestation of the deviant offender, one cobbled together in order to conform to increasingly neoconservative rationalities.

## SESSION 24.

## *Panel: Reflections on the 'Redevelopment of Riverview Psychiatric Hospital*

(Presented in collaboration with Gallery Gachet and the 2008 World Mad Pride Biennale, *One Flew West: Old Landmarks, New Topographies*)

**Marina Morrow**. Faculty of Health Sciences, Simon Fraser University
**Ann Pederson**. BC Centre of Excellence for Women's Health, BC Women's Hospital and Health Centre
**Alain Lesage.** Centre de recherche Fernand-Seguin Louis- H. Lafontaine Hospital, Montreal
**Viviane Josewski**, Faculty of Health Sciences, Simon Fraser University
**Jules Smith.** Faculty of Health Sciences, Simon Fraser University
**Lupin Battersby**. Faculty of Health Sciences, Simon Fraser University
**Brenda Jamer**. Faculty of Health Sciences, Simon Fraser University

The psychiatric deinstitutionalization movement of the 60s held out the promise of a new approach to mental illness - one that would 'return' individuals to citizenship and independent lives. Since this time, deinstitutionalization in the Canadian context has continued to unfold but with new resources and new models of care in place.

The current policy of deinstitutionalization from RVH in BC is taking place in the context of a neo-liberal regime where the reduction of social resources and, in particular housing, really amounts to 're-institutionalization' and a reinforcement of control and containment through the use of psycho-pharmaceuticals. This policy shift and literal movement of people is taking place in the context of a burgeoning discourse of 'self-management' which entreats people to direct their own care, but above all comply with their pharmaceutical routines. These two things together- the shrinking social welfare state and the neo-liberal discourses of self-management converge to undermine any theoretical intervention which might lead to a more truly progressive notion of recovery and liberation. Also, people's experiences of institutionalization and their needs and desires post-institutionalization are rarely taken into account in these discussions.

### *1. De-institutionalization in the Context of Mental Health Reform*

The transfer of people with serious mental illnesses from large psychiatric hospitals to various tertiary and supportive living arrangements in the community, continues to shape policy and care for people with the most serious and chronic forms of mental illness in the regional health authorities. While only a small population, people suffering from serious mental illness capture a substantial proportion of mental health care budgets. Thus, especially in times of restructuring, deinstitutionalization garners significant attention.

The 1998 BC Mental Health Plan called for regional self-sufficiency in mental health care through the devolution of tertiary resources from Riverview, BC's only large provincial psychiatric hospital. The final phase of the Riverview redevelopment process began in 2000 and involves relocating approximately 800 of Riverview's remaining occupants to cities and towns throughout BC. As of September 2007, 389 replacement beds have been established in BC to house former Riverview residents. At the end of the deinstitutionalization process there will be 400-500 replacement beds in the Lower Mainland and 380-415 in the rest of BC.

### *2. Madness and Citizenship in a 'Post' Institutional Age*

The psychiatric deinstitutionalization movement of the 60's was widely criticized for moving people with mental illness out of psychiatric institutions and into an unprepared 'community' which lacked the resources to provide support to these individuals. The deinstitutionalization movement coincided with the emergence of a 'recovery' paradigm in mental health that held that people with mental illness could integrate into the community and live fulfilling lives. The patronizing tenor of some of this discourse, notwithstanding, deinstitutionalization held out the promise of a new approach to mental illness – one that would 'return' individuals to citizenship and independent lives. Since this time, deinstitutionalization in the Canadian context has continued to unfold but with new resources and new models of care in place. Through the stories of individuals who have recently left Riverview Psychiatric Hospital in BC this presentation will explore the meaning of citizenship for people with mental illness in this 'post'- institutional time.

### *3. Is it really PSR?*

Custodial care models are being replaced with psycho-social rehabilitation models of care (PSR). These "new" models of care have been lauded by the government, policy makers and those overseeing and implementing the changes as 'visionary'. Indeed, preliminary findings from a tracking study of patients suggest that individuals' quality of life has generally improved in the new facilities. Our findings identified an inconsistent implementation of PSR model due to issues such as: training, facility design, understanding and interpretation of PSR and a focus on activities of daily living. Community-based supports for people with mental illness are still under-resourced and little has been done to augment services that provide important supports to assist people to gain access to the aspects of citizenship which we are all entitled such as income and education. In addition, in BC deinstitutionalization is taking place in the context of housing shortages that have created barriers for individuals ready to move into the community and live more independently.

### *4. Reflections on Gender and Social Determinants of Health*

Findings from our collaborative program of research on deinstitutionalization as it has occurred in BC's interior region suggest that the deinstitutionalization process has significant gendered implications and is also providing new opportunities for care and training that would take gender into account in the development of rehabilitation models. For example, moves of patients to new facilities have significantly shifted their relationships with families, creating new tensions and responsibilities for the mostly female family members who provide support. Staff, in turn, perceived male and female patients differently and their care was shaped by these perceptions.

It remains to be seen if a recovery model of care can fully embrace elements of citizenship such as the gendered dimensions of care, and other social determinants of health. Implicit in this is a willingness to incorporate an analysis of the social construction of oppression. Until social constructs of mental illness address stigma and discrimination, policy decisions can be made that put cost containment and social control ahead of funding responsive programs of recovery for the seriously and persistently mentally ill among us.

## SESSION 25.

## *"GAM" – A Global Approach to Psychiatric Medication for Individual and Collective Transformation**

**Lourdes Rodriguez del Barrio et Céline Cyr.** Social Work, Université de Montréal

*[* Title inspired by an activist who described the GAM approach as such, as it related to her own experience of GAM.]*

We opted to present the "GAM" initiative as we thought it was one of the most innovative, empowering, unique and useful approach to share with the wider mental health community. "GAM" stands for "Gestion Autonome de la Médication en santé mentale" or in English «Gaining Autonomy with my Medication". GAM is a novel idea developed by people who live with or have lived with mental health problems, by rights groups and by alternative mental health groups in Québec.

GAM is first and foremost a process of learning and understanding medication and its effects on all aspects of a person's life. It is a process of questioning one's needs and wants with respect to psychiatric medication. In this sense, GAM is not an end in itself, but part of the person's path toward improved well-being. This process of empowerment with regard to psychiatric medication is facilitated by support from providers, family members and peers. Moreover, by acknowledging and exploring the multiple, contradictory and changing meanings we all attribute to medication (its symbolic aspects), we learned that one is able to move beyond the opposites of "being for or against medication". Over the years, we have deepened our understanding for the integration of GAM in various community agencies and hospitals. Creating spaces of open dialogue about medication in various organisations, was and continues to be pivotal for the success of the endeavour. Last year's GAM highlight was the holding of our International Forum on GAM practices entitled, "Psychotropic medications – the answer to suffering?". *Taking Back Control – My Self-management Guide to Psychiatric Medication*, one of our documents translated into English, is starting to make inroads outside Québec . Last but not least, GAM is right in line with the exercise of free and informed consent.

In the panel presentation and workshop, 15 years of GAM development will be covered and will include: a description of the approach and tools; its history; an overview of research results and the winning conditions for implementing GAM.

## SESSION 26.
## *Hearing [Our] Voices: A Participatory Study on Schizophrenia and Homelessness*

**Barbara Schneider.** Communication and Culture, University of Calgary
**Laurie Arney.** Adult Unsung Heroes Support Group for People with Schizophrenia, Schizophrenia Society of Alberta, Calgary Chapter

*Hearing [Our] Voices: A Participatory Study on Schizophrenia and Homelessness*

This is a proposal to show a 30-minute documentary film based on a participatory action research project on Housing for People with Schizophrenia. This powerful and evocative film draws on interviews conducted with nine people with schizophrenia, who took part as co-researchers on the project. They initiated the project, developed the research question, conducted the interviews and focus groups, and now are disseminated the results. The project was led by Dr. Barbara Schneider who also appears in the film. The film has five sections. In the first section, research team members describe their experiences with schizophrenia. In the second section they describe their involvement in a support group for people with schizophrenia. In the third section they talk about their involvement in the research project. The fourth section is a segment from a dramatic performance woven from the interviews and focus groups that were conducted for the study. In the fifth section, research team members reflect on what it has meant to them to be involved in the project. The film allows people with schizophrenia directly affected by housing issues to speak about their experiences in their own words. Film in DVD format is available for preview upon request.

## SESSION 27.
## *Roundtable. The Legacy of Titicut Follies*

**Jerald Zaslove.** English and Humanities, Simon Fraser University (Moderator)
**Cherise Clarke.** Visual and Performing Artist, Activist, Gallery Gachet
**Zoë Druick.** Communication, Simon Fraser University
**Harry Karlinsky.** Psychiatry, University of British Columbia; Frames of Mind Monthly Mental Health Film Series and Annual Festival
**Endre Koritar.** Psychiatrist, Psychoanalyst, Western Branch Canadian Psychoanalytic Society, Vancouver, BC
**Robert Menzies.** Sociology and Anthropology, Simon Fraser University
**Frederick Wiseman.** Filmmaker, Director

Released in 1967 and subsequently banned by the Commonwealth of Massachusetts, *Titicut Follies* is a stark and graphic portrayal of the conditions that existed at the State Prison for the Criminally Insane at Bridgewater, and the various ways the inmates were treated by the guards, social workers and psychiatrists. As observed by film critic Richard Schickel, "*Titicut Follies* is a documentary film that tells you more than you could possibly want to know — but no more than you should know — about life behind the walls of one of those institutions where we file and forget the criminally insane. A society's treatment of the least of its citizens – and surely these are the least of ours – is perhaps the best measure of its civilization. The repulsive reality revealed in *Titicut Follies* forces us to contemplate our capacity for callouseness."

The participants in this roundtable discussion, including the creator and director of *Titicut Follies*, Frederick Wiseman, will reflect on the political, legal and cultural legacy of this landmark film, along with its impact on the international anti-psychiatry movement that emerged during the 1960s and continues in various forms today.

## SESSION 28.
## *Workshop. Crazy on the Inside*

**Les Marple.** Counselling Psychology, University of Toronto
**Shaindl Diamond.** Counselling Psychology, University of Toronto & Coalition Against Psychiatric Assault

This workshop will provide a forum for students and educators involved with mental health training programmes to dialogue about experiences with sanism and ableism in courses and placements. The facilitators will highlight current trends within the helping professions that conflict with the rights of psychiatric survivors and others vulnerable to the psychiatric system. Facilitators and participants are invited to share their personal stories of struggle and resistance as students who are psychiatric survivors or allies committed to working with an anti-oppressive framework. Participants are welcome, but not required, to bring any related art, writing or music. Possible discussion topics include coping with/challenging pathologizing language and mentalist attitudes about survivors, finding placements where students are not required to participate in harmful psychiatric practices, coming out as a psychiatric survivor in class or at work, and how to uphold one's personal ethics while completing programme requirements.

## SESSION 29.
## *Human Rights and the Socio-Legal Order in the Mental Health Complex*

**Geraldine Boyle.** Health Studies, University of Bradford, West Yorkshire, England

### *The Mental Capacity Act in England and People with Dementia: From Madness to Citizenship?*

This paper will critique the *Mental Capacity Act 2005* (England and Wales), focusing on the extent to which the law promotes the social citizenship of people with dementia. The author will highlight the historical conception of dementia as madness and explore how related assumptions have led to people with dementia being erroneously deprived of self-determination. Research which has illustrated their marginalisation in decision-making about admission to institutional care will be reviewed, and the previous lack of legal safeguards which threatened their right to liberty will be highlighted. Whilst the new law expands the civil and social rights of people with dementia, the author questions whether the Act's provisions are sufficient to protect their liberty and promote their self-determination (specifically, decision-making about institutional admission). The author will then compare this law with British Columbia legislation relating to mental capacity, focusing on the balance between protection and empowerment for people with dementia.

**Lora M. Patton.** Community and Legal Aid Services Programme, Osgoode Hall Law School, & Critical Disability Studies, York University

## *"These Regulations Aren't Just Here to Annoy You"[1]: The Myth of Statutory Safeguards, Patient Rights and Charter values in Ontario's Mental Health System*

Ontario's *Mental Health Act* (MHA) is replete with statutory safeguards established to protect patient rights and allow the invasive powers granted to physicians to comply with Charter values. Despite the substantive protections in place, rights violations occur with disturbing regularity and little is available by way of remedies for persons within the system. This incongruence suggests that while some value is attached to ensuring persons identified as "mad" are legally protected on paper, the actual law (as defined by the day-to-day operation) dehumanizes and devalues persons with difference.

This presentation outlines the legal protections established under the MHA and the judicial and administrative decisions that confirm the importance of those protections to the rights of individuals within hospitals. Three case studies are reviewed in detail. The outcomes of the cases demonstrate that this "mad law" creates significant inequalities of personhood – depending on whether one is seen as mentally healthy or otherwise.

[1] Dr. Eric Foreman speaking to Dr. Gregory House HOUSE, M.D. "1x18: Babies & Bathwater", Original Airdate on FOX: April 19, 2005. Downloaded from online script at: http://www.twiztv.com/scripts/house/season1/house-118.htm

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**Andrea Daley.** Social Work, York University

## *The Reconfiguration of Queer/Lesbian Sexuality by Service Provider Responses to Self-Disclosures*

Research is increasingly exploring the self-disclosure experiences of queer/lesbian women during their interactions with health care professionals. While self-disclosure has been associated with increased comfort and better communication, it may also increase the likelihood of homophobic victimization and discrimination during health care interactions. The majority of literature, however, has been conducted in relation to primary health care settings with less attention to self-disclosure within the context psychiatric and mental health service settings. The purpose of this study was to explore the sexuality-related psychiatric and mental health service experiences of queer/lesbian women. Participants' experiences and insights suggest that service provider responses to women's self-disclosures construct queer/lesbian sexuality as: 1) an illness or symptom of illness; 2) a cause of illness; and/or 3) being caused by trauma. Using Judith Butler's theory of performitivity I will explore how service provider responses contest and reconfigure women's performances of queer/lesbian vis-à-vis their self-disclosure narratives, and in doing so, negate women's subjective experiences of sexuality.

**Michael Johnson Jr.** Humanities & American Studies Department, Center for Social & Political Thought, University of South Florida.

*Criminalizing Sexual Deviancy: The 'Queer' Legacy of US Immigration Justice in Boutillier v. US*

United States policy regarding the admissibility of Queer peoples has had a problematic history. The use of the biomedical model to pathologized "deviancy" in terms of human sexuality has historically problematized the definition and application of "citizenship" for many American immigrants. Indeed, as recently as the 1980's it was the legislative policy of the United States to require psychiatric examination of queer individuals, under prevailing rules on "psychological" diagnosis of deviancy, for evaluation for citizenship. The purpose of this paper is to expose the historical truths associated with this policy and discuss in depth the practices employed by the US government in furtherance of this goal in the pivotal Boutillier v. INS Supreme Court Case. The goal of this presentation will be to illuminate the complex evolution of medical thought on sexual deviancy and application of the medical discipline's thinking to US legislative policies.

## SESSION 30.

## *Prison Psychiatry and Human Rights*

**Dorothy Proctor.** Activist and Author, Toronto, ON
**Kathleen Kendall.** School of Medicine, University of Southampton

*Testing the Limits of Justice: Human Experimentation in Canadian Prisons II*

Based upon extensive archival research, legal documentation, interviews and first-hand accounts, this presentation provides an overview of human experimentation conducted in Canadian prisons during the twentieth century. Although a wide range of experiments were carried out, they can be roughly categorised into three main types. 'Therapeutic' experimentation was legitimated on the grounds that it helped to discover the cause and cure of criminality. These studies included the administration of painful electric shocks, sensory deprivation, LSD and other drugs. 'Non-therapeutic' experiments were carried out in conjunction with pharmaceutical companies and other corporate interests. In these studies, prisoners were used to test such products as vitamins, aspirins, antibiotics, enema packs, food additives and pesticides. Finally, experiments designed to improve methods of 'prison management' employed solitary confinement and sensory deprivation. Factors contributing to these practices will be addressed and the paper will conclude by arguing that the dishonourable history of prison experimentation is not a thing of the past.

**Anupma Kaushik.** Political Science, Banasthali University Rajasthan, India

## *Human Right of Medical Care for Women Prisoners in India: A study of Jaipur Central Prison for Women*

The constitution of India guarantees equality to women and various laws have been enacted to protect and empower women. Some women have definitely benefited from these. However, for majority of poor and illiterate women the biased attitude of patriarchal, traditional and feudal Indian society does not offer many opportunities. The situation worsens if such women are also prisoners, for then they get branded as 'bad women' deserving bad treatment.

There are no specific provisions of prisoner's rights in the constitution of India, but they are subsumed in the fundamental rights. Moreover, various rules have been enacted from time to time which stress on welfare of prisoners including providing medical facilities to them.

These rules stipulate that the responsibility of health and treatment of prisoners rests with the medical officer and the medical officer will do complete physical and mental medical examination of prisoners at the time of admission of prisoner in the prison. She will inform the Superintendent of Prison about health, illness, pregnancy, special diet and ability to work of the prisoner. Ill prisoners will be regularly examined by Medical officer and shifted to prison hospital or government hospital for check up and treatment. If necessary a mental patient prisoner may be shifted to mental hospital or can be released temporarily for 15 days and state government can be requested for a pardon.

In our case study of Jaipur Central Prison for Women, in Rajasthan, we found that a female doctor and an assistant have been provided by the government to look after the medical needs of the prisoners. There was also a 6-bed dispensary and all medical expenses of prisoners were borne by the government.

However, conditions were far from satisfactory. There were 167 total convicted prisoners but we were allowed to contact only 150 prisoners. Out of 150 prisoners 98 i.e. 65.33% were dissatisfied with medical facilities. As per the dissatisfied prisoners they do not get enough medicines and are not referred to government doctor. Similarly 96 i.e. 64% prisoners were dissatisfied with the behavior of the doctor (doctor was changed while our study was on) who does not touch the prisoners and verbally abuses them. Prisoners also complained that influential prisoners stay in the dispensary and get special diet while ill patients rest on the floor. A few seriously ill prisoners were totally neglected. For example a 65-year-old woman Krishna, sentenced for life, was suffering from leprosy but was not getting proper treatment. Another woman named Kedar, 26 years old, had heart ailment but was termed insane and was given sleeping pills and some medicines, which she said are causing her loss of mental control.

Hence it was quite clear that laws are not properly implemented for the benefit of the prisoners. The major reason for this was 'corruption' and 'attitude' of officials who think that prisoners are bad women who do not deserve better treatment. Prisoners are so scared and dependent on officials that they can hardly do anything to improve the situation. The need of the hour is to change the attitude of the official.

**Jennifer M. Kilty.** Criminology, University of Ottawa

*Governance through Psychiatrization: Seroquel and the New Prison Order*

In this paper I will examine how prisons as archaic institutions of power, govern through the process of psychiatrization, which is a form of moral regulation. A brief history of the feminist literature on the psychiatrization of women, particularly that pertaining to women prisoners, will be presented to locate the trajectory of this process and of its discourse. By using data secured through in-depth interviews with federally and provincially sentenced women in Canada, I will demonstrate how the complaints of women prisoners (everything from substance and alcohol withdrawal, to hearing voices, depression, and insomnia) are being 'treated' with the drug *Seroquel,* which is prescribed and claimed to be of use for manic episodes, schizophrenia and bipolar disorder. I argue that this process of psychiatrization demonstrates an attempt to mitigate the women's individual citizenship, where the ability to actively engage in the regulation of their own mental health identity is reconfigured to fall under the realm and power of the psy-experts within the prison. It is important to provide a space for marginalised persons to be heard, therefore a specific emphasis will be placed upon the women's discourses and a feminist position will be taken in order to deconstruct and critique this process of pathologizing women's minds and bodies.

**Howard Sapers.** Office of the Correctional Investigator, Government of Canada

*Human Rights and Corrections: A Prison Ombudsman's Perspective*

An important challenge for all countries, even advanced democracies, is guaranteeing the human rights of its prisoners. The quality of regard to, and respect for, human rights impacts on the success of prisoners' reintegration and participation in society. This presentation will review the legislative mandate of the Office of the Correctional Investigator (Federal prison Ombudsman) and the Office's role in fostering a correctional environment respectful of Canada's domestic and international human rights obligations. The delivery of mental health (MH) services to federal offenders will be focused on through a human rights lens. Mentally ill prisoners are entitled to programs and MH services that meet their needs and which conform to professionally accepted standards of care; yet the number of prisoners suffering from significant MH issues is increasing and mental health care continues to be inadequate, impacting on both their period of incarceration and their timely release back into the community.

## SESSION 31.
## *Workshop. Fight Back Against the Mental Health System*

**Megan Oleson and Lisa Wulwik..** Mental Health Political Action Group, Vancouver

The Mental Health Political Action Group is a group comprised of people who have encountered the mental health system. We are all people who have come together to fight back against a system that we find to be inherently oppressive. We are a newly-formed group and our first action is the production of rights cards around areas of committal. This is a crucial issue because many patients in hospital do not know their rights or even what it means to be committed. We are also producing a pamphlet on how our mental health act compares to other provinces and how the mental health act interacts with our basic human rights. We also hope to do “flying squads” into the hospital to help patients who are in need of finding advocacy.

## SESSION 32.
## *Toward a Critical History of Madness*

**Geoffrey Reaume.** Critical Disability Studies, York University and Co-founder, Psychiatric Survivor Archives, Toronto

*Mad Markers: The Politics of Remembering Mad People’s History*

How history is remembered is suffused with all kinds of variables. This can range from the availability of documentary evidence, individual and inter-generational memories, as well as whose interpretation is given greater attention and why. This paper will discuss the politics of remembrance in mad people’s history to examine what kinds of public markers exist on this topic, how these markers attempt to explain mad people’s history, and the extent to which people who have lived this history have been involved in this memorializing of their past. Public markers will include monuments, plaques, buildings, cemeteries and similar objects of physical culture by and about mad people. The point of this presentation will be to argue that the *process* of remembering mad people’s history is crucial to its presentation while also ensuring that this past contributes to social justice for psychiatric survivors today.

**Kathleen Kendall.** School of Medicine, University of Southampton, England

### *Patient Experiences in Canada's First 'Laboratory for the Scientific Study of Criminal Insanity'*

This presentation explores the experiences of patients incarcerated in the Rockwood Criminal Lunatic Asylum between 1857 and 1877. During this twenty-year period, the institution, located near Kingston, Ontario, reputedly served as a laboratory for the study and treatment of criminal insanity. A range of archival sources will be used to examine the following: the individual troubles and social processes which contributed to the imprisonment of approximately 1,000 patients; the psycho-legal ideas, systems and interventions which regulated patient lives; and the diversity of patient experiences inside the institution. As one of the earliest stand-alone establishments for the treatment of 'criminal insanity', Rockwood played an important role in shaping our understanding of and response to 'criminal insanity'. Therefore, engaging with the experience of those confined within its walls deepens our understanding madness, citizenship and social justice in Canada.

**Onar Usar.** Critical Disability Studies, York University

### *Psychiatrized Women Speaks Out: Exercising Agency, Demanding Human Rights in Phoenix Rising*

By the mid twentieth century biological psychiatry had clearly failed to fulfill its great promise to "cure" mental illness. This period was also shaped by the growth of several popular social movements, particularly second wave feminism, gay liberation, and anti-psychiatry movement. These developments led to patient/consumer/survivor activism that exposed the atrocities of psychiatric practices disguised under the rubric of "medical treatment." *Phoenix Rising: The Voice of the Psychiatrized*, a unique Canadian antipsychiatry journal published by psychiatric survivors between 1980 and 1990 in Ontario, came to life in the midst of this psychiatric survivor/consumer activism. For a decade *Phoenix Rising* provided a forum for psychiatrized people to share their stories and offered positive alternatives to "psychiatric warehouses." This paper looks at published letters written to *Phoenix* editors, as well as first person psychiatric survivor narratives of women featured in the journal, and explores the ways women psychiatric survivors exercised their agency and claimed their rights for full citizenship. Drawing upon a Foucauldian notion of modern power relations and discourse analysis, a particular emphasis is given to the extent of which the voice of female psychiatric survivors play in the creation of alternative discourses and transformation of social structures.

**Mel Starkman** Psychiatric Survivor Archives, Toronto
**Geoffrey Reaume.** Critical Disability Studies, York University, & Psychiatric Survivor Archives, Toronto

*Mad Archivists and Mad People's History: Psychiatric Survivor Archives, Toronto*

This presentation will discuss efforts to document mad people's history by focusing on the work of the Psychiatric Survivor Archives,Toronto (PSAT). Founded in 2001, PSAT's efforts to preserve our community's international history will be discussed in regard to examples from our collection, the importance of community building through historical preservation, sustaining and maintaining the collection and problems encountered along the way. The support of psychiatric survivors, community partners and donors from far afield will be noted as being of crucial importance in supporting the work of mad archivists and preserving mad people's history for posterity.