The main interest in life and work is to become someone else that you were not in the beginning. If you knew when you began a book what you would say at the end, do you think that you would have the courage to write it? What is true for writing and for a love relationship is true also for life. The game is worthwhile insofar as we don't know what will be the end. (Foucault 1988)

University of Alberta

The Politics of Coming Out: Stigma and Biomedical Models of Mental Disorder

by

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Abstract

Drawing from philosophical, clinical, sociological, and activist literatures, my work critically analyses the deployment of biomedical models of mental disorder as a means of targeting stigma. I argue that "the stigma of mental illness," when conceptualized within a biomedical framework, functions to 1) incite a multitude of discourses surrounding mental disorder, 2) extend the reaches of psychiatric surveillance and classification, and 3) streamline individuals and populations into particular modes of conceptualizing and disciplining the self. I argue that the rhetoric of stigma creates a series of new confessional venues, and determines the language and grammar through which mental disorder is made to speak. As a result of these scripts, counter narratives are outlawed, and their authors (i.e. consumer/survivor/ex-patient and Mad Pride activists) are routinely denied advantages accrued by socially authorized truth-tellers. I therefore conclude that the biomedical framing of anti-stigma rhetoric and discourse is, in part, complicit with the power relations that mark some individuals as mad. As such, anti-stigma discourse does not represent a radical break or historico-political rupture with "the stigma of mental illness" but is derivative of it. In light of these issues, I seek to develop an account of how we think about the functioning of, and relationship between, knowledge and power within anti-stigma discourse. My overarching concern, therefore, is not with what stigma *is*, but resides rather with what talking about stigma *does.*

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Introduction

Research Focus

When I first began this project, my intention was to engage with the stigma literature from a philosophical perspective and attempt to offer some sort of alternative insight into the stigma of mental illness, one that did not rely on the biomedical model as a means of displacing responsibility. Part of this research was devoted to understanding academic perspectives on the stigma of mental illness. The other part of this research was spent trying to develop an overall picture of public perceptions of mental illness, and how anti-stigma campaigns were being circulated in the public domain. I spent an increasing amount of time on mental health advocacy websites, and taking all sorts of mental health check-up questionnaires. I listened to podcasts and radio shows. I read memoirs of mental illness and recovery. I collected newspaper clippings, and promotional materials from different stigma-busting campaigns.

It seemed everywhere I turned, there it was, in big, bold letters "**the stigma of mental illness.**" The ubiquity of this language, however, was more than a mere heightened academic awareness of the issue. There it was, written on posters in the university's hallways, on public transit placards, even on signs in bathroom stalls. And in turning on the television or radio, or sitting down over coffee with friends, it seemed everyone was talking about *it*. There was a palpable insistence to it all. The persistence of these injunctions to speak and the confessions being made, brought me to question how and why people were talking so incessantly about something that is, purportedly, so stigmatized and silenced. This questioning precipitated a profound shift in the focus of my research. I was no longer concerned so much with the concept and processes of stigmatization, so much as with the forms of discourse that were rapidly and explosively emerging as a result of the talk of stigma itself. A new set of questions materialized: Why all the talking? Why all the talking in this particular, biomedicalized frame of reference? What does the talk of stigma do? What sorts of knowledge claims, power relations, experiences, and subjectivities arise as a result?

Background

The Stigma of Mental Illness

The word *stigma* comes from ancient Greece, and was initially used in reference to signs or symbols physically cut into or burned onto the bodies of those deemed to be of an inferior status.[1] It was a marking of one's tarnished and flawed character. Today, stigma is more often attached to one's social standing, personality traits, or psychological makeup. "People are no longer physically branded; instead they are societally labeled—as poor, as criminal, homosexual, mentally ill, and so on. These labels influence public perceptions and behavior and lead to devaluation and denigration of those who are so labeled" (Wahl 1999, 11–12).

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[1] A version of part of this chapter has been published. Thachuk, Angela K. "Stigma and the Politics of Biomedical Models of Mental Illness." *International Journal of Feminist Approaches to Bioethics* 4.1 (2011): 140-63. Print.

Modern usage of the term *stigma,* and contemporary focus on the concept as a topic of academic inquiry, were initiated most notably by Erving Goffman in his germinal work, *Stigma: Notes on the Management of Spoiled Identity* (1963). Here Goffman defined stigma as “an attribute that is deeply discrediting,” one that contracts identification of its possessor from “a whole and usual person to a tainted, discounted one” (1963, 3). The discredited trait becomes the signifying trait to which the entirety of the individual is reduced and identified. Goffman advises, however, that when discussing stigma we speak in “a language of relationships, not attributes” (1963, 3). Stigma does not merely reside within or attach to marked individuals. Rather, it is dialogical in nature. While individuals may deviate from any one of a number of normative standards (e.g., physical, characteriological, racial, national, and/or religious), it is “we normals” who make possible the stigmatization of such deviations (Goffman 1963, 4). Through our attitudes and behaviours toward such marked persons, “we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce [their] life chances” (Goffman 1963, 5). Thus for Goffman, the stigmatizing process is distinctly a relational one.

The stigma associated with mental illness is by now well documented (see, for example, Hinshaw 2007; Sayce 2000; Wahl 1999). Persons with mental illness are viewed as socially disruptive, dangerous, difficult to treat, and responsible for their disorders (Hayward and Bright 1997). Collectively, these stereotypes create a context that many of those diagnosed with mental illness describe as more painful and debilitating than the illness itself. Stigma impedes those living with mental illness from securing housing (Page 1996). It undermines their consideration as eligible candidates for employment, threatens job security, and limits possibilities for professional advancement (Wahl 1999, 79–86). It hinders development of interpersonal relationships (Angermeyer, Matschinger, and Corrigan 2004; Link et al. 1999; Wahl 1999, 43–60). Finally, it infringes upon access to and coverage for adequate mental health services (Hinshaw 2007, 178–81).

In terms of healthcare access, prejudicial attitudes toward mental illness play out on a number of levels. First, the stigma associated with mental illness inhibits many from seeking help for fear of being labelled "mentally ill" (Corrigan 2004). Second, the legitimate health concerns of those patients already labelled mentally ill are often viewed through the lens of their diagnosis. When histories of psychiatric treatment are disclosed, individual complaints are often not taken seriously, and care is compromised (Wahl 1999, 69–74). Finally, it has been suggested that underfunding of mental health research and service provision is also the result of stigma (Corrigan et al. 2004). For example, in 2005–2006, only 6.67 percent of the Canadian Institutes of Health Research funding was committed to mental health and addictions research (Farr 2009, 10). As Neasa Martin and Valerie Johnston suggest:

> When faced with competing demands for finite public resources, legislators often choose to invest in other, more 'worthy' causes, rather than support a system designed to serve those with little

> political influence, for whom the public has little sympathy and who are believed to be beyond hope. (2007, 11)

Thus, the stigma associated with mental illness influences the decision to seek care, the type of engagement one might encounter in the clinical setting, and the variety of resources available due to existing funding and research.

These damaging consequences have garnered increasing attention at the international, national, and grassroots levels. For example, the World Psychiatric Association, along with the joint efforts of twenty participating countries, launched its “Open the Doors” campaign in 1996. This particular program specifically targeted the stigmatization of and discrimination against persons with schizophrenia (“Open the Doors” n.d.).[2] The World Health Organization formed its own alliance on mental health in 2001, setting as one of its primary concerns the tackling of the stigma associated with mental illness in all its various manifestations (WHO 2001).

New Zealand’s successful and well-established “Like Minds, Like Mine” program is often highlighted as an exemplary model for mental health educational strategies at the national level (“Like Minds, Like Mine” n.d.). “Like Minds, Like Mine” tends to focus more explicitly on *discrimination* against persons with mental illness as opposed to advancing its platform on the conceptual framework of *stigma.* As such, this program is more explicit in its concern with the relational processes that mark persons with mental illness as other. Much of their platform is premised upon a legal- and disability-rights framework, and as such, devotes more

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[2] See also World Psychiatric Association (2001).

energies to reinstating the benefits of full citizenship so often denied to persons with mental illness. Acknowledging that not all forms of discrimination can be regulated by formal legislations, attention is also paid to informing the public of the role they play in the recovery of persons with mental illness. As one of their campaign slogans declares, “For people with mental illness, the biggest barrier to recovery is discrimination. What you do makes a difference” (Like Minds, Like Mine 2010).

Within the Canadian context, anti-stigma initiatives have historically tended to take a more piecemeal approach, given that as of 2006 Canada bore the dubious status of being the only country among the G8 nations that did not have an established national mental health strategy.[3] The Mental Health Commission of Canada (MHCC) was established in March 2007 to begin addressing this gap (MHCC 2012). One of the commission’s three key initiatives has been the launching of a ten-year anti-stigma campaign. In October 2009, the commission officially launched its “Opening Minds” initiative, the first phase of which is geared toward youth aged twelve to eighteen, and healthcare professionals, particularly frontline workers like family doctors, nurses, and emergency room staff. Given the early onset of many mental illnesses, the hope is that targeting younger populations will increase treatment-seeking behaviour in the earlier stages of symptom presentation. The campaign also seeks to change the practices of healthcare professionals, given the frequency with which persons with mental illness are discriminated against within the clinical setting.

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[3] For a historical overview of anti-stigma efforts and programming in Canada, see Heather Stuart (2005).

At the grassroots level, a wide range of groups campaigning around mental health issues has sprung up over the last several decades. For example, in the 1970s and 1980s, there was a major trend toward the establishment of self-help and mental health advocacy groups initiated by parents of children with mental illness (Hinshaw 2007, 82). The most notable of these is the US-based National Alliance on Mental Illness (NAMI). NAMI's primary goals are to support and advocate on behalf of individuals and families living with mental illness, and to educate and raise awareness regarding diagnosis, treatment, and recovery. Since its inception in 1979, NAMI has become one of the most extensive advocacy organizations in the United States, with more than 1,200 local affiliates throughout the country, and an information website (*nami.org*) that receives upward of 750,000 visitors each month.

NAMI is not only most notable for the extent of its membership base, outreach, and influence, but also for its explicit and emphatic endorsement of a biomedical model of mental illness. Like a host of other advocacy groups, including the National Alliance for Research on Schizophrenia and Depression (NARSAD), NAMI adopts a biomedical model of mental illness as a central tool in its anti-stigma armamentarium (see, for example, Valenstein 1998, 176–82). Broadly stated, biomedical models of mental illness suggest that the etiological basis of mental illness resides in the body's physiological processes. These processes can ostensibly be located in a deficiency or excess of neurotransmitters, in hormonal imbalances, and/or in genetic predispositions. Proponents endorsing the biomedical model as an anti-stigma tactic contend that likening mental illness to physical illness legitimizes the individual's experience of helplessness, undermines the assumption that those with mental illness are simply weak-willed, and increases accessibility to healthcare services.

Psychiatry and Biomedicine

The emergence of the relationship between psychiatry and biomedicine is a complex one, and it is not the goal of this dissertation to offer either a history or an anthropology (see, for example, Luhrmann 2000). A few background features of this relationship, however, are pertinent to help contextualize the discussion that follows. From the outset, it is important to recognize that the notion that mental illness resides in the body is not a contemporary one. The conceptual evolution of mental illness is often misconstrued as advancing in a linear fashion from superstitious demonological accounts to more enlightened biomedical models. This progression has, in fact, been much more cyclical, and closer examination reveals that historical perspectives often blended together spiritual and scientific accounts of mental illness, rather than strictly adhering to either one side or the other of an explanatory dichotomy (Hinshaw 2007, 54).

This blended approach is no less the case today, where psychiatrists in the contemporary North American context are socialized into two different etiological frameworks (Luhrmann 2000). On the one hand, psychiatrists are trained in the biomedical model of mental illness, with its emphasis on brain functioning and psychopharmaceutical treatment, while on the other hand, they are also trained in more psychodynamic or psychosocial oriented approaches to mental illness (Luhrmann 2000, 25-83). From the latter perspective, individual personalities and life histories play a key role, and treatment consists primarily of developing insight into one's experiences, emotions, and behaviours through talk therapy. Thus both models are still present in psychiatric training and practice, each offering different perspectives, and modalities of treatment. Nevertheless, for a number of different reasons, biomedical models have come to dominate North American psychiatry.

Since the 1950s, biomedical models of mental illness have been on the increase in North American psychiatry. Prior to this, theories regarding the chemical origins of mental illness were generally not in circulation. This does not mean that such theories were entirely absent, nor is it to suggest that chemical compounds were not previously used to alleviate symptoms of mental illness. Rather it is only meant to mark the turning point at which the biomedical model began its rise to its preeminent positioning. One of the most significant factors responsible for the revival of interest in biological theories of mental illness was the discovery of effective pharmaceutical treatments. For example, chlorpromazine was originally developed in the 1940s to market as an antihistamine. Previous antihistamine research had revealed a series of "side effects," including sleepiness and detachedness, which would prove of interest to several different psychiatrists. Later trials would reveal the drug's ability to calm agitated and confused patients, reduce paranoia, and diminish insistence of auditory hallucinations (Valenstein 1998, 20-35). The introduction of different drugs for the treatment of schizophrenia in the early 1950s (like chlorpromazine), and increased marketing of minor tranquilizers and anti-depressants later in the decade precipitated what would become the broad uptake of biological models of mental illness. Depression and other mental disorders came to be understood as "chemical imbalances" in the brain, the remedy for which came in the form of psychiatric drugs.

This foray into a more substantiated biomedical approach was also taken up as the panacea psychiatry was seeking in its attempt to mitigate the strident critiques being levelled against it in the 1960s and 1970s. At the time, critics argued that psychiatry was more rightly understood as an agent of social control, one which lacked any firm, objective basis for its modes of classification, practice, and treatment. Attempts to align itself with biomedicine were thus also motivated by professional interests in enhancing its own epistemic authority within the scientific community and the public eye. This alignment was facilitated, in part, by extending its reaches into fostering further development of new pharmaceutical treatments.

The introduction of fluoxetine (Prozac) in the late 1980s, like the introduction of other "wonder drugs" before it, sparked renewed hope for biological solutions to mental illness. This optimism was again magnified when the United States Congress declared the 1990s to be the "Decade of the Brain" (Bush 1990). This declaration was motivated by desires to raise interest in the value and benefits of brain research and neuroscience, and promote the public's mental health literacy. During this period, research primarily investigated new forms of treatment, and what they had to reveal about the etiological basis of mental illness. Today, biopsychiatric research has come to focus more directly on the causes of mental illness through the development of neuroimaging technologies, investigations into genetic predispositions, and research on neural circuits and plasticity. Thus major strides have been made from the beginning stages of research in which the role of several neurotransmitters were of primary concern to a more expansive consideration of contributing influences.

Given the broad scale of research being done in terms of the etiological foundations and treatment of mental illness, one cannot underestimate the economic interests at stake. These interests have played a sizeable role in the wedding of psychiatry to biomedicine, and in the dominance of biological psychiatry in North America today. On the one hand, the financial interests of pharmaceutical companies loom large. Profits depend heavily on whether or not diagnosed individuals understand mental disorder as something requiring a pharmaceutical solution. On the other hand, increased financial cutbacks to healthcare services in the Canadian context, coupled with the increase of managed care in the United States has meant that pharmaceutical remedies are more likely to be prescribed for economic reasons given that they are purportedly less taxing to already overburdened systems.

The relationship between psychiatry and biomedicine has also been fostered by mental health service users and advocates. Biomedical models are actively deployed as a tactic to target the stigma of mental illness. By displacing attributions of responsibility onto the "morally neutral" body, proponents argue that they diminish the stigma associated with mental illness. Campaigns premised on this notion circulate in the form of public service announcements, promoting a biomedical understanding of mental illness within the social imaginary.

Overall Aim and Research Objectives

In this dissertation, I critically analyse the deployment of biomedical models of mental disorder as a means of targeting stigma. I broadly support moves to target the stigma associated with mental disorder; however, while biomedical models may increase understanding of mental disorders (or mental disorders as illnesses), I argue that they cannot be deployed as a talisman to ward off stigma. The discourse of "the stigma of mental illness," when conceptualized within a biomedical framework, functions to 1) incite a particular way of talking about mental disorder, 2) extend the reaches of psychiatric surveillance and classification, and 3) streamline individuals and populations into particular modes of conceptualizing and disciplining the self.

I argue that the rhetoric of stigma creates a series of new confessional venues, and determines the vocabulary and grammar through which mental illness is made to speak. As a result of these scripts, counter-narratives are outlawed, and their authors (such as consumer/survivor/ex-patient and Mad Pride activists) are routinely denied the advantages that accrue to socially authorized truth-tellers. I therefore conclude that the biomedical framing of anti-stigma rhetoric and discourse is, in part, complicit with the power relations that mark some individuals as mad. As such, anti-stigma discourse does not represent a radical break or historico-political rupture with "the stigma of mental illness" but is derivative of it. In light of these issues, I seek to develop an account of how we think about the functioning of, and relationship between, knowledge and power within anti-stigma discourse. My overarching concern, therefore, is not with what stigma *is*, but resides rather with what talking about stigma *does*.

In examining these issues, I speak to four main sets of conceptual concerns. First, what sorts of power and knowledge claims arise from the situating of stigma discourse within a biomedical framework? Second, how are biomedical models of mental illness theorized? With whom do they hold sway? What are the perceived benefits for those who think the models are truth-revealing? Third, what are the detriments of speaking in biopsychiatric vernacular? At what point do analogies drawn mental and physical illnesses begin to breakdown? Finally, what sorts of narratives and subjectivities emerge when one conforms to the biomedical script? What are its effects on the narratives and subjectivities of those persons seeking to offer an alternative discourse and live a different relationship to their madness?

Methodology

The tactics I have pursued in answering the above questions are quite varied, and as a result this dissertation is highly interdisciplinary. I draw from a broad range of philosophical, clinical, sociological, anthropological, and activist literatures. I engage with mental health advocacy websites, talk show podcasts, Youtube videos, courtroom cases, and a wide spectrum of personal memoirs and narratives. My analysis of these literatures concerns itself with the concepts embedded in them, how they get used, and their political implications. As such, my approach is largely theoretical, as opposed to offering an in-depth analysis of particular bodies of empirical research. I pursue this tactic in order to flesh out the implicit values and interests circulating around and within much of the stigma discourse, something that is not easily captured through reference to empirical data alone. This sort of data does, of course, prove invaluable in providing further support for my arguments, and illustrating the more tangible and concrete effects of the concepts I work with.

Within the literature I engage, it quickly becomes apparent that whether one adopts *mental illness*, *mental disorder*, or *madness* as their label of choice, these categories function as umbrella terms meant to capture a broad range of experiences. These umbrella terms are characteristic of the majority of the academic literature and mainstream anti-stigma campaigns, with the exceptions being those studies and initiatives speaking directly to the stigma associated with a particular disorder. Nevertheless, the use of these terms is a source of recurring debate, where tensions exist between the respective benefits and detriments of breaking the terms down or maintaining their catch-all function.

One the one hand, breaking these umbrella terms down into their separate categories introduces a set of worrisome issues. First, positioning mental illnesses along some sort of continuum potentially re-instantiates the us/them dichotomy. "'We' have mild depression, while 'they' have real mental illness – schizophrenia for example" (Everett 2006, 26). Thus, while this approach might promote awareness of variance between different mental illnesses, it does not alleviate the stigma associated with "serious mental illnesses." In fact, doing so might only work to reify their already magnified tainted status. Second, as David Pilgrim and Anne E. Rogers argue, the breaking down of particular stigmas associated with particular mental illnesses “does not privilege *stigma* but starts at the other end of the telescope – with particular *diagnoses*” (2005, 2549 emphasis in original). In the process, diagnostic categories are naturalized, and so too are the stigmas associated with them. This overshadows the extent to which these categories remain highly contested, and “may mystify our understanding of the social forces, which both cause and codify them” (Pilgrim and Rogers 2005, 2551).

On the other hand, while attempting to address a broad range of diagnoses, these umbrella terms can be homogenizing in their effects, overshadowing important differences both within and between particular categories of psychiatric classification. Furthermore, one might argue that these umbrella terms allow for a sort of conceptual creep. By now, it is clear that biomedical psychiatry has its hold on the paradigmatic bio-disorders, and is extending its reach to bring the more psychosocial disorders into its fold. In fact, to even draw such distinctions at all between the biological and psychosocial disorders is already to relinquish a great deal of the model’s conceptual power in terms of solidifying perceptions of mental disorders as medical conditions. For this project, then, the most philosophically important feature of umbrella terms is how they get used to expand the conceptual domain of biomedical psychiatry. As such, except in those instances where I refer to particular diagnoses, I do not attempt to break these umbrella terms down in to their specific components.

I recognize that in doing so I risk appearing that I am too cavalier with those diagnoses that are very clearly brain-based (for example, schizophrenia), and that my analysis works best with more amorphous diagnoses like depression, or with those that have a more obviously psychosocial component, like anorexia. I am aware that not all disorders are easily captured in the way I depict them, especially within the earlier chapters where I focus on the broad scale effects of medicalized anti-stigma initiatives, where these umbrella terms circulate. As stated, however, my goal here is limited to an interrogation of the ways in which these umbrella terms are in fact used and the ends to which they are put.

The umbrella terms I use throughout the dissertation vary between "mental illness," "mental disorder," and "madness." This variance is dependent upon the particular context of the discussion. Thus, for example, many advocacy campaigns and policy documents refer to the stigma of mental illness and so when making direct reference to these I employ the term mental illness. In contrast, when engaging in dialogue with the narratives of consumer/survivor/ex-patients and Mad Pride activists, I use the term madness. Generally speaking, however, I have adopted mental disorder throughout the project. I do so in order to differentiate my positioning from advocates of a more strictly biomedical model of mental illness. This is not to suggest that I deny the role biology plays. Rather it reflects my position that overemphasizing its role obfuscates the social, political, and environmental factors that contribute to the trajectories of mental disorder and the stigmatization of persons so labelled.

Finally, I use the term *advocate* to refer to those individuals (living with a psychiatric diagnosis or not) who, in their engagement with anti-stigma campaigns, generally work from within mainstream concepts of mental disorder, and with organizations more closely associated with the biomedical model. I use the term *activist* to refer to those individuals (labelled or not) who take up a more critical stance towards the mental health system, and processes of psychiatric identification, classification, and treatment.

In later chapters, I focus more narrowly on specific conditions like depression and schizophrenia – both for which frontline therapy generally consists (at least in part) of pharmaceutical treatment. This selective focus passes over other sorts of conditions, for example, age-related dementias, affective disorders from brain injuries and strokes, and conditions, like kleptomania, for which pharmacological treatments are not frontline courses of care. Certainly these other diagnoses are also marked as stigmatized locations, and each posses their own relationships with the biomedical model. My choice to set these conditions aside is based on the fact that the majority of the academic stigma literature, mental health advocacy networks, and anti-stigma campaigns tend to limit themselves to a particular range of conditions, primarily anxiety disorders, attention deficit disorders, bipolar disorders, eating disorders, mood disorders, and schizophrenia. Thus, at least for the purposes of this project, the generalizations I make are not meant to extend to these other conditions, and the conclusions I draw are directed precisely toward the sorts of conditions that fall within the purview of the discourses I am engaging.

This is distinctly a feminist analysis, but not one that focuses exclusively on women's issues. My method and theoretical framework, however, is largely indebted to feminist philosophy in a number of ways. First, this analysis is motivated by a concern for the relational processes that contribute to and structure both the marginalization and empowerment of individuals and groups (see, for example, Mackenzie and Stoljar 2000). As stated by Susan Sherwin, "Feminist methodology directs us to evaluate practices within the broader scheme of oppressive social structures" (1992, 118). From this perspective, I set as one of my primary tasks the contextualization of the social, political, and historical features of the environment in which the individual is situated, and to remain attuned to the power relations and differentials that influence one's locations and positionings within the social landscape. Part of the struggle inherent to this particular mode of analysis is remaining attentive to and respectful of the embodied experiences of those individuals whose lives are implicated in the theories of oppression and in any strategies for overcoming marginalization. With respect to mental illness in particular, Norah Martin suggests that "One of the biggest challenges for feminist bioethics, and for feminist ethics more generally, is how to deal with the tension between care for the suffering of individuals and concern for issues of power and oppression that must certainly be the basis of any feminist analysis of psychiatry" (2001, 438). Second, this work is driven by a deep commitment to understanding the forces contributing to the epistemic marginalization of oppressed persons, and how the unequal distribution of epistemic authority and credibility maintains and reinforces existing social hierarchies (Alcoff 2001; Code 1987; 1991; 1993; 1995; Fricker 1998; 2003; 2007). Trust and epistemic authority are often conferred in accordance with the social and institutional norms and structures of a given context, and I take this point as central to my analysis of the legitimacy conferred on experiences of mental illness through the process of medicalization. Finally, my work draws from and contributes to the feminist literature regarding the unpredictable effects of “strategic essentialism” (see, for example, Sedgwick 2008, 40-44; Heyes 2009, 137). Strategic essentialism suggests that, as a political tactic, appeals to some form of essentialism can be made without fully endorsing authentic or universal traits and/or characteristics of a given group. In other words, one can recognize its descriptive limitations and still use it to further one’s political goals. A strategic biological essentialism underpins many advocacy campaigns, wherein appeals are made to an essential body as a means to mitigating stigma. I make clear why we ought to be troubled by and wary of such appeals, when such appeals are premised upon a body that is conceptualized as existing prior to and independent of socio-cultural power relations. Collectively, these influences structure and guide my questioning of the deployment of biomedical models of mental illness as an anti-stigma tactic, and reveal its broader application to other areas of feminist concern.

Values of Research

Given its interdisciplinary methods, the values of my research are broadly based and are potentially of use to a number of different beneficiaries. First, this project aims to fill some of the gaps in the stigma of mental disorder literature. To date, this literature remains largely uncritical in terms of querying the extent to which the concepts deployed and the ways in which the problem itself is configured might be flawed and/or damaging. Because this particular body of literature largely informs mental health policy and the development of anti-stigma strategies, this research also has the potential to offer fresh and alternative insights into how these policies and campaigns might be improved. For example, I illustrate how current anti-stigma strategies are exclusionary and constraining in their effects. This offers a starting point from which to question how these campaigns might be less marginalizing. Second, given that the project takes the biomedical model to task, it has the potential to inform how practitioners might better interact and engage with persons presenting with mental disorders. I argue that likening mental illness to physical illness is limited in its benefits, and potentially instigates a series of damaging effects. Analogies are helpful, but they are incomplete. As such, practitioners might want to give pause before comparing mental disorder to diabetes, and psychopharmaceuticals to insulin. Arguments such as this one might encourage practitioners to reconsider how they relate to, inform, and treat patients. Third, given the project's emphasis on personal narratives of mental disorder and madness, it is a potential resource for those struggling with psychological distress, and those contemplating, seeking, and/or receiving mental health services. Finally, the project contributes to the literature on the consumer/survivor/ex-patient and Mad Pride movements. My presentation of narratives issuing from within these movements, and contextualization of them within the broader anti-stigma discourse illustrate the hardships of attempting to mount a psychiatric-resistant positioning. While these movements are receiving increasing attention, general knowledge about them is still largely lacking. As such, I sincerely hope that this research will bring increased awareness to the struggles these activists face, and begin to carve out a space in which madness can speak.

Outline of Chapters

Chapter two *The Stigma Hypothesis* begins with an in-depth analysis of Michel Foucault's account of the repressive hypothesis as detailed in the preliminary sections of *The History of Sexuality, Volume 1: An Introduction* (1978; hereafter abbreviated HS1). Here, Foucault argues that contrary to historical claims that sexuality was repressed in the Victorian era, there was in fact an explosion of discourses around sexuality, premised upon the very notion that it was silenced. This explosion ushered in with it a whole new array of ways to speak about sexuality, and new confessional venues in which to do so. Aligning myself with Foucault's arguments regarding the functioning of the repressive hypothesis in the Victorian era, I introduce what I term the "stigma hypothesis." This hypothesis suggests that rather than mental disorder being silenced in the contemporary context, the current preoccupation with the stigma of mental disorder has introduced a whole new spectrum of technologies and modes of speech in which confessional discourses arise. To illustrate the effects of what the talk of stigma does, I present popular examples of how this discourse functions in the public domain in the form of stigma-busting campaigns.

It is not enough to say that we are incited to speak endlessly about what is wrong with us (the function of chapter two), we must also understand the form and content that speech takes. Thus, chapter three, *Biomedical Model of Mental*

Disorder: Speaker's Benefits, begins to fill out the language of the biomedical model of mental disorder that the stigma hypothesis promotes, and the benefits that derive from speaking in this vernacular. I suggest that the biomedical model of mental disorder is as much a product of historical contingencies and vested interests as it is a legitimate scientific paradigm. To support these claims, I depict this model as functioning, simultaneously, as a site of scientific inquiry, a source of professional identity and epistemic authority, a cultural location, and a hub of economic activity. The benefits of conceptualizing mental disorder as a biomedical issue are discussed under each of these headings.

Chapter four, *Biomedical Model of Mental Disorder: Speaker's Detriments*, offers a critical analysis of biomedical models of mental disorder by revealing the subterranean and often unpredictable effects precipitated by this style of thought. Alongside the series of speaker's benefits discussed in chapter three, I illustrate a series of detriments incurred by those who speak and are spoken about in these terms. I accomplish this through following the same analytical rubric developed in the previous chapter, wherein I conceptualized biological psychiatry as, at once, a site of scientific inquiry, a source of professional identity and authority, a cultural location, and a hub of economic activity. I conclude that while biopsychiatric logic is enabling in certain respects, its strategic deployment as an anti-stigma tactic is also politically dangerous.

In chapter five, *"Breaking the Silence" – The Politics of Coming Out,* I shift my perspective from the broader institutional levels examined in chapters three and four, to examine the effects of the biomedical model of mental disorder on a more localized level. I begin the chapter with a brief review of contemporary feminist and Foucauldian concepts of experience in order to provide the theoretical background that informs my reading of two different texts. The first of these texts is Ladelle McWhorter's *Bodies and Pleasures: Foucault and the Politics of Sexual Normalization* (1999; hereafter abbreviated BP), which provides a critical analysis of sexual identity politics and the politics of coming out. McWhorter's unique reading of Foucault's texts coupled with the way in which she interweaves her personal experience with her critical engagement of these texts is an important contribution to Foucauldian and feminist theory. I use her work in order to draw analogies between her critiques of coming out narratives in gay politics and the coming out narratives of persons with mental disorder. Elizabeth Wurtzel's *Prozac Nation: Young and Depressed in America, A Memoir* (2000 [1994]; hereafter abbreviated PN) exemplifies the influence that dominant narrative forms have on processes of self-constitution and production. This memoir is illustrative of but one of the confessional venues that stigma discourse has enabled, and epitomizes how this discourse narrows the range of possible experiences and the stories one might tell about them. I conclude that given the speaker's detriments outlined in chapter four, and the value structures that underwrite mainstream psychopathographies, confessional narratives (of the dominant form) do not represent a radical break with the stigma hypothesis but rather are complicit with it.

In chapter six, *Coming out Mad: or Why I'm Anti-Anti-Stigma*, I further the discussion set up in chapter five to illustrate how the dominant psychiatric narrative script is not only constraining for those who conform to it, but also how it works to outlaw the narratives of those wishing to offer a counter-discourse of their experiences with the mental health system. The narratives of consumer/survivor/ex-patient (c/s/x) and Mad Pride activists offer an alternative perspective from which to take measure of anti-stigma discourse and the dominant narrative forms it produces. To set the context, I begin with a brief historical overview of the c/s/x and Mad Pride movement. I illustrate how the movement fits within the mainstream discourse, and what the movement does differently. I close by drawing attention to how the c/s/x and Mad Pride movement's non-compliance and/or resistance to biopsychiatric logic embroils its members in a politics of rationality that threatens their ability to be heard, subsequently impeding their capacity to be read as credible and reliable truth-tellers. As a result, activists are routinely denied the same advantages accrued by those individuals who adhere to the confessional practices and terms of reference of the dominant style of thought in biomedical psychiatry.

I conclude that the assumption that there are only benefits to be garnered from the wedding of anti-stigma tactics to biomedical models of mental disorder must be reconsidered given the overwhelming constraints it imposes at the institutional level and at the level of the individual. The propensity of this tactic to dictate a prescribed narrative script structures the experience of mental disorder in particular ways, such that those offering a counter-discourse are inhibited in their attempts to mount a psychiatric-resistant politics. Anti-stigma campaigns are laudable in their goals, and certainly have had positive effects. However, given their tendency to reinforce the very terms of reference they are trying to de-stigmatize, I conclude that I am anti-anti-stigma. My work, therefore, contributes to the current explosion of literature on the stigma of mental disorder by calling into question and offering a philosophical critique of the very foundations upon which much of this research is grounded.

Chapter Two

The Stigma Hypothesis

> What is peculiar to modern societies, in fact, is not that they consigned sex to a shadow existence, but that they dedicated themselves to speaking of it *ad infinitum*, while exploiting it as *the* secret (HS1, 35 emphasis in original).

Within the field of mental health a great deal of energy has been devoted to the analysis and conceptualization of the stigma associated with mental disorder. It has been taken up as an object of study from within a variety of academic disciplines, and also serves as a rallying point for a number of different governmental and grassroots mental health advocacy organizations. As suggested in the introductory chapter, these anti-stigma campaigns are motivated by a number of different laudable goals, one of which is to encourage individuals who are suffering to seek professional help. Posters in the hallways of universities, notices from human resources, televised public service announcements, radio talk shows, and the pages of local and national newspapers all beseech the public to speak up and take the stigma out of mental illness.[4] Individuals are urged to engage in open dialogue, dismantle the walls of silence, and, at long last, bring

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[4] For an example of academic institutional anti-stigma initiatives, see "Putting a Face on Mental Illness." For a series of radio interviews with Edmontonians diagnosed with depression regarding anti-stigma tactics, see "Edmontonians Living with Depression." For an example of national news coverage, see *The Globe and Mail's* (2008) weeklong special series on mental illness entitled "Breakdown: Canada's Mental Health Crisis." Similarly, "Breaking Through" was an ongoing special report in *The Globe and Mail* in partnership with the Mental Health Commission of Canada geared towards raising awareness of and tackling the stigma associated with mental disorder.

mental illness out of its deep dark shadows. Forever. The question is: if mental disorder is indeed shrouded under a veil of silence, why all the talking?

I suggest that this apparent paradox is not all that mysterious, especially when considered in light of Michel Foucault's arguments against the repressive hypothesis as detailed in *The History of Sexuality* (HS1, 17-49). In general, the repressive hypothesis suggests that sex and sexuality in the Victorian era were silenced under the weight of a repressive force issuing from the demands of a moralizing bourgeois society that was undergoing rapid industrialization. Foucault concedes that indeed certain strictures were imposed in terms of how and where one might speak of sex and sexuality. At the same time, however, there was also a widening and intensification of discourses on sex. Rather than being silenced, sex was made to speak in a whole new range of ways and locations, and with unprecedented precision and detail. As Foucault has famously argued, what we encounter in the Victorian era, rather than a silencing of sex, is an incitement to discourse.

Modelling my argument after Foucault's, I articulate what I term the *stigma hypothesis*. I suggest that talk of "the stigma of mental illness" 1) incites a multitude of discourses surrounding mental disorder, 2) extends the reaches of psychiatric surveillance and classification, and 3) organises individuals and populations into particular modes of conceptualizing and disciplining the self. More specifically, I argue that the rhetoric of stigma promotes and sustains a proliferation of medicalized discourses, creates a series of new confessional venues in which to speak, and determines the vocabulary and grammar through which we might do so. I suggest that the proliferation of mental health promotional material and anti-stigma rhetoric in the public domain promotes routine self-surveillance of our moods and behaviours. Held in check against the seemingly fine-tuned nosological classification of moods and behaviours marked as dysfunctional, our own moods and behaviours are increasingly experienced and understood as potentially symptomatic of a psychiatric disorder.[5] In other words, the rhetoric of stigma "conducts our conduct," and enables a specific trajectory and set of disciplinary techniques in terms of mood hygiene and management. Embedded within a public health model, the rhetoric of stigma encourages the uptake of psychiatric classification and nomenclature as the contemporary lens through which we have come to understand ourselves. That is, the rhetorical deployment of the "new science of stigma" constrains and enables new ways of speaking about and experiencing the self. I conclude that anti-stigma rhetoric and discourse are, in part, complicit with the power relations that mark some individuals as mad, and that anti-stigma discourse does not represent a radical break or historico-political rupture with the stigma hypothesis but is derivative of it. My argument, then, is not that stigma does not exist, and nor does it intend to deny the damaging effects that stigma has on the help-seeking behaviours of those who are suffering, or the very real consequences it has for people already labelled with a psychiatric diagnosis. Nor do I deny that there are certain edicts and restrictions imposed upon how and where mental disorder is spoken of. Rather my argument is about stigma *discourse*, one in which I seek to develop an account of

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[5] Nosology is the branch of medicine that deals with the classification of diseases.

how we think about the functioning of and relationship between knowledge and power within that discourse.

In pursuing this position, I begin by setting out in some detail Foucault's argument regarding the repressive hypothesis and incitement to discourse from *The History of Sexuality.* My use of Foucault's argument is not only analogical; Foucault's text is not only a genealogical account of sexuality but is also a history of psychiatry, wherein the pathologization and psychiatrization of perverse pleasure functions as a key example. Foucault's critique of the repressive hypothesis thus provides both theoretical form and historical content upon which to ground my own analysis, in which I connect contemporary stigma discourse and the functions of repression discourse in the Victorian era.[6] In line with Foucault, I present and justify what I term the *stigma hypothesis* as an alternative way of thinking about what the talk of stigma does. My guiding question is thus not "What *is* stigma?" but rather "What does talking about stigma *do*?" To illustrate these effects, I present popular examples of how this discourse functions in the public domain in the form of stigma-busting campaigns.

Foucault's History of Sexuality

Foucault opens *The History of Sexuality* by sardonically recounting the oft-told story of the ushering in of sexual repression with the Victorian era:

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[6] The historical accuracy of Foucault's claims regarding 18th and 19th century sexuality has been challenged. Foucault might have been wrong, but I suggest that something parallel is correct about attitudes towards mental disorder. It is not so much his historical assertions that support my analysis, so much as the conceptual elegance of his point regarding the performative contradiction between suggesting that something is silenced, while at the same time speaking loudly about how it is repressed.

> At the beginning of the seventeenth century a certain frankness was still common, it would seem. Sexual practices had little need of secrecy; words were said without undue reticence, and things were done without too much concealment; one had a tolerant familiarity with the illicit. Codes regulating the coarse, the obscene, and the indecent were quite lax compared to those of the nineteenth century. It was a time of direct gestures, shameless discourse, and open transgressions, when anatomies were shown and intermingled at will, and knowing children hung about amid the laughter of adults: it was a period when bodies "made a display of themselves."
>
> But twilight soon fell upon this bright day, followed by the monotonous nights of the Victorian bourgeoisie. Sexuality was carefully confined; it moved into the home. The conjugal family took custody of it and absorbed it into the serious function of reproduction. On the subject of sex, silence became the rule. (HS1, 3)

This master narrative paints a stark contrast between the sort of carefree and jovial sexuality preceding the early stages of the 1600s, and the repressed and sanitized atmosphere of the Victorian era (1837-1901), which was the culmination of a long period of gradual repression. Foucault argues that the accuracy of this popular story is suspect. What it fails to bring into full relief is the proliferation of discourses on sexuality that emerged during this same period, the seemingly endless extent to which sex was spoken about, classified, made into an object of knowledge and source of personal identity. Thus the apparent paradox: If indeed Victorians were so repressed, how do we account for the fact that, during the

Victorian era, sex became a widespread topic of scientific investigation, medical examination, nosological classification, and the focus of confessional narratives?

Foucault argues that the continued dominance of the repressive hypothesis can be attributed to a number of different but interrelated factors. The first is that a plausible origin story of sorts has been detailed with respect to the repression of Victorian sexuality. The rationalization here is that history and its subjects had entered into a period in which both sex and sexuality fell under the control and domination of the new capitalistic order. Sexual repression became a necessary part of the political order of things, a tool to enhance productivity through limiting the expenditure of one's energies on fulfilling the body's desires. The pursuit of sexual pleasures became inconsistent with the newly imposed work ethic except when limited to more productive and utilitarian instances (HS1, 6). Sex was restricted to and becomes the domain of the married couple for the purposes of reproduction. The positioning of this narrative of a repressed sexuality in alignment with Marxist critiques of the emergence of capitalism secured its dominance and its continued circulation.

The second factor encouraging the uptake of the repressive hypothesis, according to Foucault, results from the particular conceptualization of power embedded in the first. Here, power is understood as something that always functions negatively. Its operations are always somehow limiting, restrictive, and/or repressive. Power, in this negative (or juridical) sense, is conceptualized as a force that is imposed upon something, functioning as a means of control in the political order of things. Power, then, is something that acts upon or holds back sexuality, "... [imposing] its triple edict of taboo, nonexistence, and silence" (HS1, 5). Thus another false assumption generated when power is conceptualized in this way is the belief that sexuality is a discrete entity existing prior to, independent of, and external to the repressive forces of power. Human sexuality, at its base, is a natural human instinct, drive, or force. It is not a product of power, but rather something that power acts upon, restricts, and represses.

The final false assumption upholding the repressive hypothesis, and instigated when power is conceptualized as purely negative, is that truth and knowledge are necessarily freeing. "If sex is repressed, that is, condemned to prohibition, nonexistence, and silence, then the mere fact that one is speaking about it has the appearance of deliberate transgression" (HS1, 6). An atmosphere is thus created in which speaking the truth of one's sex functions as a form of resistance on the path to personal liberation and self-realization. Foucault refers to this "deliberate transgression" as the "speaker's benefit" (HS1, 6). He suggests:

> What sustains our eagerness to speak of sex in terms of repression is doubtless this opportunity to speak out against the powers that be, to utter truths and promise bliss, to link together enlightenment, liberation, and manifold pleasures; to pronounce a discourse that combines the fervor of knowledge, the determination to change the laws, and the longing for the garden of earthly delights. (HS1, 7)

In other words, one interprets one's speaking up, out, and against the restrictions imposed on sexuality as an active exercise of one's agency, a liberatory act promising the hope of a future freedom. "Confession frees, but power reduces one to silence; truth does not belong to the order of power, but shares an original affinity with freedom...” (HS1, 60). We experience the confessional ritual as liberating, forgetting how it constrains us in particular ways. Collectively, these false assumptions regarding the nature of power, knowledge, and sexuality form the foundations upon which advocates of the repressive hypothesis premise their belief that a natural, ahistorical human sexuality was held back and contained by an external, controlling, negative form of juridical power, the antidote to which was to speak about sex and sexuality, to speak about them loudly, and as often as one possibly might.

Contrary to the supposition that speaking of one’s sex is an act of resistance, Foucault argues that, in fact, all this talking issues from within the repressive hypothesis itself. Speech acts do not represent a rupturing from a repressive past. Sex is not silenced. Sex is still spoken about. It is simply spoken about in newly prescribed ways. True, there were certain edicts and restrictions imposed on speech acts regarding sex -- for example, codes pertaining to when and where one might speak of sex, the sorts of discretions that must be observed, and, yes, in some instances, that sex remains silent. Nevertheless, concomitant with these restrictions on more localized acts of speech came a diversification and proliferation of discourses and expansion of domains. Rather than a series of totalizing restrictions, what we encounter is the “dissemination and implantation of polymorphous sexualities” (HS1, 12).

The compulsion to speak of everything down to the smallest of details reveals itself in the “scandalous” literature of the period, including the publication of *My Secret Life* between 1888 and 1894 by an anonymous Victorian gentleman known only as “Walter.” While this publication entailed eleven full volumes in which Walter describes his sexual encounters in explicit detail, Foucault suggests that it is an oversimplification to understand this authorship as a radical transgression of the edicts imposed on sexuality. A more complex reading of Walter sees him as a prime example of the newly minted secular compulsion to speak about sex in all its details. In other words, he is not so much speaking out in direct opposition to the edicts imposed upon Victorian sexuality so much as he is partaking of the new secularized sites created in which to do so.

Medicine, psychiatry, and the criminal justice system were all involved in manufacturing this explosion of discourses on sexuality and their attendant sites of confession. The famous example offered by Foucault to illustrate how and where these domains and discourses converged and functioned is the case of Jouy. Jouy, the story goes, was a simple-minded man from the village of Lapcourt, who in 1867 was handed over to the authorities for receiving “caresses from a little girl” (HS1, 31). Upon detention, Jouy was subsequently handed over to a doctor and two other experts, and his case report later published. Foucault suggests that the significance of this example resides in its “pettiness,” stemming from:

> the fact that this everyday occurrence in the life of village sexuality, these inconsequential bucolic pleasures, could become, from a certain time, the object not only of a collective intolerance but of a judicial action, a medical intervention, a careful clinical examination, and an entire theoretical elaboration. (HS1, 31)

Far from being silenced, while such acts were now condemned, they were simultaneously put into discourse, replete with a technical and rational language stripped of any frivolity that might have attached to it in the past. In this way, Jouy's actions no longer represented momentary indiscretions but rather revealed something about his true nature. His actions become indicative of the *kind* of person he was – a paedophile.[7]

Foucault suggests that there are strong connections to be drawn between the "licentious Englishman" who recorded his voluminous sexual exploits and the simple-minded Jouy. Although the energies compelling them to speak and the form their words took varied from one man to the next, "sex – be it refined or rustic – had to be put into words. A great polymorphous injunction bound the Englishman and the poor Lorrainese peasant alike" (HS1, 32). In other words, the profound connection linking the two men is that they were both subject to the forces of the period that made sex a matter of public interest, a matter that must be put into words, and made to speak exhaustively. These injunctions took different forms--for the Englishman an anonymous yet public confession removed from the sanctity of the Christian pastoral, for Jouy the interrogations of a civil and medical system that submitted his innermost desires and thoughts to juridico-medical scrutiny and analysis. Different forms, different injunctions, and yet made to speak just the same. The cases of the Englishman and Jouy are illustrative of the multiplicity of locations and the polymorphic nature of the injunctions to make

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[7] Foucault's controversial treatment of the case of Jouy has been largely debated in feminist circles given the gender-blindness of the example, and the manner in which he fails to acknowledge the seriousness of child-adult sex, and/or rape. For a range of positions in the debate see, for example, Alcoff (1996); Taylor (2009); and Oksala (2011).

sex speak and be known, Foucault argues. This discursive explosion is therefore not to be understood as emanating from a singular centralized location. “Incitements to speak were orchestrated from all quarters, apparatuses everywhere for listening and recording, procedures for observing, questioning, and formulating” (HS1, 32-33).

Thus Foucault’s tactic is not to measure the degree to which sexuality was or was not repressed, but rather it is to examine the forms of power circulating around and through the sexualities of the “other Victorians,” such as Walter and Jouy. He proposes four primary means through which the functionings and effects of power were in fact productive and not merely repressive. The first way power functions with regards to sexuality is that it generates *lines of penetration* into spaces that previously did not fall under medical scrutiny - in this instance, the family is of primary concern (HS1, 41-42). Children’s sexuality was conceptualized as organized around masturbation, and efforts were made to abolish it. Parents were put on guard both in terms of regulating and surveying their children’s behaviour, as well as eliciting confessions when required. Parents were also put on guard to the possibility that they might not be stringent enough in ferreting out and disciplining their children’s sexuality, thereby subjecting even themselves to new forms of self-surveillance. Thus although efforts to abolish masturbation were doomed to failure, Foucault contends that campaigns to eradicate children’s “solitary habits” nevertheless successfully worked to infiltrate the familial space with new forms of surveillance, knowledge, and tactics of interrogation.

Second, “this new persecution of the peripheral sexualities entailed an *incorporation of perversions* and a new *specification of individuals*” (HS1, 42-43). The infiltration of psychiatric power transposes the significance of sex and sexuality from the moral realm to the medical domain. It comes to reveal something about the individual’s psychological interiority, one’s true nature. Aberrant sexual perversions morph from being momentary acts to being symptomatic of certain kinds of people - significance shifts from practice to person. “Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphroditism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species” (HS1, 43).

The advent of Victorian sexology and the psychiatrization of sexual perversity thus ushered in the categorization of new kinds of individuals premised on the basis of their sexual proclivities, Foucault says. The medicalization of perverse pleasure would subject these new kinds to the forces of a psychiatric power that claimed sexuality as its domain of jurisdiction and judgement. The truth of our sex must be made to speak if we are to know our true selves, and given its secretive nature professionals are needed to ferret out and make sense of our sexual confessions. Foucault states:

> The obtaining of the confession and its effects were recodified as therapeutic operations. Which meant first of all that the sexual domain was no longer accounted for simply by the notion of error or sin, excess or transgression, but was placed under the rule of the

> normal and the pathological (which, for that matter, were a transposition of the former categories)...(HS1, 67)

Medicalization of the process and effects of confession meant that, "spoken in time, to the proper party, and by the person who was both the bearer of it and the one responsible for it, the truth healed" (HS1, 67). Speaking was to be understood as a cathartic experience central to restoring one's healthy sexuality. New objects and relations of power/knowledge emerge, constraining and enabling new sorts of relationships, identities, and forms of intelligibility.

Third, these incitements to discourse, and the naming and classifying of different sexualities create "*perpetual spirals of power and pleasure*" (HS1, 44-45). In other words, power and pleasure are mutually constituting and reinforcing. By creating the appearance of sexual constraint, the repressive hypothesis creates a situation in which the secrets of one's sex need to be drawn out by those with the authority and knowledge to do so. Those persons facilitating the requisite examinations – doctors, parents, teachers, and psychiatrists - are brought into direct contact with those they are investigating – patients, children, students, and madmen. The examiners derive pleasure from the power which both qualifies them, and results from, their authoritative status within these dyads. Likewise, the intensity of being observed and questioned regarding one's sexuality brings one's sexual pleasures into acute focus, intensifying one's awareness of them. In this way, pleasure is sometimes magnified for the examined. Pleasure is also derived from knowing that one is able to evade and hide valued specifics from the questioner. Thus, in one context, one might derive a sense of defiance and pleasure in speaking in opposition to the strictures on sexuality, while, in another context, the same individual might derive pleasure in concealing their sexuality from those who want to make it speak (HS1, 45).

The fourth way in which power makes its presence more forceful is through *devices of sexual saturation* (HS1, 45-49). Foucault suggests that while we often conclude that the effects of this repression have been to confine sexuality to the heterosexual married couple, this is, in fact, not the case. Rather, what has occurred is the emergence of a multiplicity of different means and strategic points from which to seek out, name, and make possible a diverse array of sexualities and perversions. This is particularly the case with regards to the family unit, which witnessed the imposition of a series of structures and codifications that defined and governed the sexualities of its members. For example, expectations emerged encouraging separate sleeping quarters for parents and children, and boys and girls. Concerns grew over the rules of decency with regards to breastfeeding, and, as previously mentioned, childhood masturbation became an area of overt concern and surveillance. In other words, the family became yet another site of pleasure/power. For Foucault, these examples illustrate the point that while these new codes were, to a certain extent, restrictive and oppressive in their effects, they simultaneously worked to create new networks of power/pleasure, new forms of sexuality, and new kinds of individuals. Thus the type of power involved here:

> …did not set up a barrier; it provided places of maximum saturation. It produced and determined the sexual mosaic. Modern

> society is perverse, not in spite of its Puritanism or as if from a backlash provoked by its hypocrisy; it is in actual fact, and directly, perverse. (HS1, 47)

The compulsion to speak was also encouraged by an increasing public interest in discourses on sex, especially sexuality qua mental illness. More than simple curiosity of the masses, Foucault points to growing public interest during this period with the regulation and governance of "populations," and the power that attends this. Concern grew with birth and death rates, patterns of health and illness, fertility, consequences of contraceptive usage, and all other sorts of details that shape the vigour and robustness of a population. Discourses on sex were central to these forms of knowledge for they rationalized access into areas previously cordoned off from external scrutiny, analysis, and intervention (HS1, 26):

> It was essential that the state know what was happening with its citizens' sex, and the use they made of it, but also that each individual be capable of controlling the use he made of it. Between the state and the individual, sex became an issue, and a public issue no less; a whole web of discourses, special knowledges, analyses, and injunctions settled upon it. (HS1, 26)

Technical, economic, and political interests compelled sex to speak, resulting in the coding, classifying, and naming of sex (HS1, 23). These new discursive forms shifted sex beyond the boundaries of the pastoral confession, leaving behind a language of sex defined by the strictures of Christian morality for one defined by the principles of rationality (HS1, 24). "...One had to speak of it as of a thing to be not simply condemned or tolerated but managed, inserted into the system of utility, regulated for the greater good of all, made to function according to an optimum" (HS1, 24).

Medicine, psychiatry, and pedagogy thus all refined techniques for and dispersed and entrenched confessional practices throughout the "sex lives" of individuals. The scientific authorization of these confessions and personal reflections was accomplished through a number of different processes, which worked to reformulate the evidentiary validity of these information sources (HS1, 65-67). First, incitements to speak were fashioned within a clinically codified manner, abstracting confessions through formalized examinations and questionnaires. Second, sex was postulated as the causal root of almost everything. In this way, everything concerning one's sexuality, even at the most removed reaches, became of interest for the effects it may have. Third, sex was not something that simply revealed itself, but was secretive and elusive. The confession was necessary in order to bring out what was hidden not only from the examiner but also that which was hidden from the examined. Fourth, scientific credibility was conferred upon one's confessional narrative only once it had traversed through specific modes of interpretation. In other words, unmediated confessions were not scientifically valid. The speaker offers up his or her narrative, but it is the listener's "function to verify this obscure truth: the revelation of confession had to be coupled with the decipherment of what it said.

The one who listened was not simply the forgiving master, the judge who condemned or acquitted; he was the master of truth" (HS1, 66-67). Finally, confessions were brought into the realm of scientific validity through the medicalization of their effects.

The cumulative effect of these validation processes worked to invoke the formation of a naturalized understanding and conceptualization of sexuality. Sexuality became:

> …a domain susceptible to pathological processes, and hence one calling for therapeutic or normalizing interventions; a field of meanings to decipher; the site of processes concealed by specific mechanisms; a focus of indefinite causal relations; and an obscure speech *(parole)* that had to be ferreted out and listened to. (HS1, 68)

The pathologization of perversities and the medicalization of confessional events mutually constituted the truth of sexuality, formulating a body of knowledge that could then be deployed for productive purposes, including the control and regulation of populations – all this in a time of an ostensibly deeply entrenched repression. As in the Victorian era, contemporary adherence to the notion of repression and the misassumptions it breeds continues to enable these trajectories.

The Stigma Hypothesis

As with Victorian sexuality, mental disorder is said to exist under a shroud of silence. Given the negative stereotypes associated with mental disorder, and the often-damaging consequences of revealing one’s psychiatric diagnosis, mental disorder has best been left to dwell in the family attic. In essence, it too has endured the consequences of a “triple edict of taboo, nonexistence, and silence” (HS1, 5). Or so we are told. Yet despite its ostensible stigmatization, knowledge production surrounding mental disorder has not slowed. To the contrary, mental disorder has persisted as a topic of widespread discussion, scientific investigation, medical examination, nosological classification, and confessional narrative. The question arises: Why, if mental disorder is so stigmatized, is everyone talking about it? How did this come to be, and what forms of knowledge/power are made possible as a result?

In alignment with Foucault’s critique of the repressive hypothesis outlined in the previous section, I argue that there is a series of false assumptions supporting the contention that mental disorder is silenced. These false assumptions include the beliefs that 1) power only functions negatively to repress and constrain, 2) truth and knowledge are liberating and stand in opposition to power, and 3) mental disorder is a natural kind, understood here as an entity that exists independent of, and is not contingent upon, human influence or invention. When these false assumptions are promoted, taken up, and put into practice, the consequences directly echo the productive effects of power articulated by Foucault, including 1) an incitement to discourse, 2) an extension of the reaches of psychiatric surveillance and classification, and 3) the organization of individuals and populations into particular ways of conceptualizing and experiencing the self. Thus my tactic is not to measure the degree to which mental disorder is or is not silenced. Rather it is to examine the forms of power circulating around and through the discourses that result from the suggestion that it is. Nor do I deny that mental disorder is stigmatized in very tangible and concrete ways. What I want to show, however, is that as with the repressive hypothesis, the power in circulation in stigma discourse not only restricts and represses, but also intensifies and incites.

To ground my articulation and defence of the stigma hypothesis and its effects, I take as my primary working example the University of Alberta's anti-stigma campaign *Facing Facts.* I adopt this example not only because I think it important to reflect upon and critique the practices of the institutions with which we are (whether implicitly or explicitly) most closely aligned, but also because I take this example to be representative of the form and content of the multitude of anti-stigma campaigns circulating in the public domain. I analyse its form and content, then, to begin debunking the stigma hypothesis. My critical analysis of the University's campaign is not meant to undercut the value of its intentions. Many individuals suffer alone and do not seek help because of stigma. There is also no doubt that failure to seek help can translate into diminished productivity, increased absenteeism, and pose threats to both individual and public health and safety. In this way, the effects of stigma discourse can be enabling. The framing of these issues within a biomedical model of mental disorder, however, can also be deeply constraining. What I am interested in for the moment, however, is not so much the tangible benefits or detriments of these campaigns but rather the hidden curriculum embedded in anti-stigma discourse of which I take *Facing facts* to be an exemplary model.

"An Incitement to Discourse"

Facing Facts, initiated in late 2007, is described as "an on-going program designed to tackle the stigma of mental illness, with the goal to raise awareness, dispel myths and encourage a healthy dialogue about mental illness" ("Facing Facts" n.d., n.p). The following passage is an excerpt from an email sent by Health Promotion and Work*Life* Services at the University of Alberta to its faculty in February 2009 as a part of this awareness program:

> Once a year we see our Doctor for an annual physical, take our car in for a tune-up and plan for a vacation. But generally, we do not take the time to assess our mental health. Even if we feel fine 2009 is a great time to make mental health a priority.
>
> You can start by doing a "Check up from the Neck Up" on-line assessment. Sleep disruption, excessive worry, lethargy, self-medicating with over the counter drugs, or persistent sadness are specific warning signs that you need to follow up on with your Doctor. Your mental health deserves as much attention as your physical health and safety.
>
> You can make a difference by being aware of mental illness and being open to discussion. The more mental health is discussed, the greater the chance we have to reduce the stigma. (Personal communication, Cressida Heyes quoting a circular to faculty from

> University of Albert Health Promotion and WorkLife Services, 2009)

For further information, faculty are encouraged to visit the *Virtual Wellness* website where visitors are immersed in a morass of material. One is led through a labyrinth of self-assessment tools, like the Mood Disorders Association of Ontario's "Check up from the neck up," and the Canadian Mental Health Association's "Mental health meter," as well as the Mental Health IQ quiz to assess one's mental health literacy. There is a series of Mental Illness Fact Sheets, ranging in topic from anxiety and depression to eating disorders and Internet addiction. There are online courses and workbooks, as well as access to the program's communication memos distributed throughout the campaign, which include such titles as "Putting a face on mental illness," "Mental health check up," and "I think I need some help."

The *Facing Facts* campaign and other campaigns of its kind are, in part, incited by stigma discourse and themselves incite further discourse. They are the result of an international dialogue concerning the stigma of mental illness, and in turn they beseech others to speak up. Mutually reinforcing events such as these have instigated a "veritable discursive explosion" (HS1, 17) within and around the anti-stigma movement of the last several decades. Like much of the other stigma-busting material out there, the University's campaign suggests that speaking out is the solution, wherein "overcoming stigma" seems to amount to talking about what is wrong with you. As another programme communication from *Facing Facts* suggests, it is only through talking about the facts of mental illness that stigma can be tackled: “**Put the elephant on the table ~ it helps to talk about it!**” (“Dispelling Myths” n.d., n.p.).

This idea that mental disorder is a looming issue that people do not want to openly acknowledge and discuss is also the central focus of the Mood Disorders Society of Canada’s “The Elephant in the Room” national anti-stigma campaign (“Elephant” n.d.). This campaign offers little blue elephants people can display in their offices or homes to let others know that this particular environment is a safe and non-stigmatizing space in which one can speak of mental health issues. COPE, a student-led mental health initiative at McMaster University, has partnered with MDSC to bring the blue elephants to campus in order to raise mental health awareness, encourage people to speak up, and tackle the stigma associated with mental illness (COPE n.d.). As stated in one of COPE’s promotional videos, “We need to talk about the elephant in the room to work towards a stigma-free campus” (COPE n.d.).

The notion that freedom from stigma resides in our increasing capacity and willingness to talk about mental disorder is also the pivotal message of Bell Canada’s 2012 “Bell Let’s Talk Day.” Canadian Clara Hughes, six time Olympic medalist, was the national spokesperson for Bell’s public service announcement, in which she reveals that while she is generally known for her athletic achievements, what most people do not know is that she battled with depression for two years. She continues, “One in five Canadians is affected by mental illness, and many will not get the help they need because they’re afraid to talk about it, and this has to change. So, on February 8th, Let’s Talk!” (Bell Canada 2012, n.p.).

On February 8th, 2012, Bell pledged five cents to Canadian mental health programmes for each text, long-distance call, and re-tweet. The successful outcome of this was a $3,926,014.20 donation (Bell Canada 2012, n.p.). These funds are in addition to Bell's September 2010 announcement to launch its $50,000,000 mental health initiative (Marlow and Picard 2010, n.p.). Parts of these monies have been specifically designated towards stigma research, including the establishment of the world's first chair in anti-stigma research at Queen's University. Thus the effects of anti-stigma discourse are not to be undervalued. They are enabling and productive in all sorts of ways.

Awareness, continued research, and stigma-free environments can be realised through our capacity for speech. As the tagline from England's biggest anti-stigma and discrimination campaign, *Time to Change*, states, "It's time to talk. It's time to change. Let's end mental health discrimination. Start your conversation now" (Time to Change n.d., n.p.).[8] And talk about it we do. We are confessing animals (HS1, 59). We speak endlessly to all who will listen -- on talk shows and radios, in hushed whispers over conference luncheon tables. And then there are the "ears for hire," our doctors, therapists, and psychiatrists who bear witness to our confessions, who stand as interpreters of our experiences, who make sense of our inner worlds, and reflect them back to us in ever more coherent and transparent forms. Siphoned through the filters of their expert knowledge, our psychological dispositions, inner thoughts, desires, perversions, and private behaviours and compulsions blend to form a more accurate picture of the kind of

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[8] This campaign has also produced an interesting and innovative series of videos, short films, and television advertisements. See, for example, Time to Change (2012).

person each of us truly is. To confess is to make these elements speak. It is to lay these elements bare to scrutiny, to make them known, and it is this knowledge, this newfound self-awareness that purportedly forges the pathway to self-discovery and liberation.

We eagerly partake in and consume the products of the proliferating venues in which confessions of mental disorder are offered up. Like the explicit and scandalous literature of the Victorian period, new confessional genres have sprung up in response to stigma discourse. Written accounts of one's struggles with mental disorder abound, wherein detailed accounts are given of individual struggles with mental disorder and journeys to recovery (see, for example, Behrman 2003; Blackbridge 1997; Jamison 1993; Solomon 2001). Some of these have been best sellers, others made into major motion pictures (see, for example, *Prozac Nation* 2001). We might well want to celebrate the courage and tenacity it takes to write, publish, and film these accounts given the negative beliefs surrounding mental disorder that circulate widely in the public domain. Given the potentially damaging effects of coming out with a mental disorder, these are acts of bravery. However, as with those who authored scandalous accounts of their sexual forays in the Victorian era, to understand these acts as transgressing the strictures of silence would oversimplify the complexities associated with these sorts of confessional events. As with these earlier writers, authors of these "autopathographies" are a product of the very hypothesis that they seemingly stand in opposition to. They are indicative of a newly instigated compulsion to speak about mental disorder, while "exploiting it as *the* secret" (HS1, 35 emphasis in original). In other words, these individuals are not so much speaking out in opposition to the repressive forces that would have them silenced, but rather they are participants in the new sites created in which to make their disorders speak under the newly sanctioned rationale for doing so.[9]

We were shamed. Now we are ashamed of this shame, and demand that our mental disorders be let out of the closet. Sexual perversions are but one among many of the psychological deviances that come to signify and reflect the kinds of people that we are. And it is a saddening fact that one must be made to hide these interiors away only because they might reveal a dark and despairing psychology. The suggestion that our psychological salvation resides in our courage to speak out in opposition to the shaming silence is directly analogous to Foucault's claims about overcoming the repression of sexuality. As Ladelle McWhorter sardonically states of the repression of sexuality:

> An injustice has been committed against sexuality, and we have to set things right; an injury has been done us at the site of our most intimate being, and we have to heal it. Our principal means of doing these things is to talk about sex and sexuality as much as possible, to bring our sexuality 'out into the open,' to name and affirm it. ...[It] is quite simply a kind of therapy that we all must undergo. (BP, 12)

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[9] This point will be articulated in some detail, in chapter five, through a close reading of an exemplary model of this sort of autopathography, Elizabeth Wurtzel's (2000 [1994]) *Prozac Nation: Young and Depressed in America, A Memoir*.

So too with our moods and psychological interiors, we must bring them out into the open, name them, affirm them. We all must undergo some kind of therapy, take part in our annual "Check Up from the Neck Up." We are all subject to a certain incitement. Even if you are not mad, you are always on the lookout for signs that you might be heading in that direction.

"Lines of Penetration"

This increasing emphasis on mental health is easily understood as an extension of public interest into the regulation and governance of populations that once took sexuality qua mental illness as one of its targets of focus. The classification and documentation of the psychological difficulties of a given population seems an obvious expansion of the range of vital statistics historically deployed in determining the vigour and robustness of a population. Indeed, the impact of mental illness is routinely measured in terms of economic burden, and most individuals are acutely aware that "the loss of mental health can mean loss of employment and income, or even loss of the normal self. Conversely, productivity losses are said to be signs of possible decline into full-blown major depression" (Gardner 2003, 126).[10] Abnormal sleeping patterns, energy levels, and moods, as well as excessive time spent on the internet all pose potential threats to an individual's livelihood and a nation's economic productivity. Thus increasing the channels through which to monitor, classify, and discipline such abnormal behaviours becomes of the utmost importance. Online assessments like

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[10] For example, the estimated total economic burden of mental illness in Canada for 2003 was an approximated $51 billion (Kim et al. 2008).

“Check up from the neck up” and other public service announcements beseech people to speak up about their emotional problems, to report them to their healthcare providers, promising some sort of liberation in reward for transgressing the barriers of silence. People more freely offer themselves to examination, encouraged by all sorts of sources to do so – employers, healthcare providers, friends, and television advertisements - thus enabling entry into the most private of spaces. And if individuals do not submit themselves to such assessments and discuss the outcomes with their healthcare providers, then more overt measures can be and are taken to ferret out this information. As Allan Horwitz and Jerome Wakefield suggest of the US nationwide depression-screening movement, “if people would not come in for diagnosis, then diagnosis must go to the people” (2007, 145). New *lines of penetration* are pushed into areas previously cordoned off from external scrutiny and surveillance (HS1, 41-42).

Ellen Feder argues that the familial unit is particularly vulnerable to this sort of infiltration. As in the Victorian era, the family continues to act as one of the primary sites through which psychiatry exerts its normalizing power. Feder suggests, however, that the parental disciplinary gaze is only partially responsible for these effects. Disciplinary gazes exerted from outside of the family home’s walls also come to bear upon and normalize the behaviours and relations contained therein. Thus the family itself, as an institution, is subjected to new lines of penetration, especially as children enter out into the world of friends, neighbours, classmates, and teachers who all implicitly come to constitute a form of surveillance (Feder 1997, 199; Feder 2007, 50). Children’s behaviours are scrutinized by classmates and teachers, and gazed upon by other families (Feder 2007, 50). When considered abnormal or deviant, these behaviours and transgressions are submitted to further disciplinary measures in order to diagnose, and treat both the child and the family, particularly the mother (Feder 2007, 51-53). These effects are made possible only against a background in which there is a defined set of normative standards against which one is judged and disciplinary surveillance is deployed to reinforce them; and it is in relation to these standards that the individual emerges, both non-deviants and deviants, enforcers and enforced (Feder 2007, 54).

"Incorporation of Perversions and Specification of Individuals"

This continued emphasis on the stigmatization of mental disorder and insistent calls to speak up has increased the extent to which we submit our moods and behaviours to psychiatric assessments, channelling us more readily into conceptualizing ourselves in terms of the ever-expanding array of diagnoses under which our behaviours might be classified. In this way, stigma discourse has also entailed "an *incorporation of perversions* and a new *specification of individuals*" (HS1, 42-43 emphasis in original). As abnormal moods come to signify something greater than mere "problems of living," psychological deviance falls ever more consistently within the jurisdiction of psychiatric power and nosological classification. "Sleep disruption, excessive worry, lethargy, self-medicating with over the counter drugs, or persistent sadness are specific warning signs that you need to follow up on with your Doctor" (personal communication, Heyes 2009). These warning signs are behavioural abnormalities that must be monitored, and depending upon the cluster of symptoms you present with, assessments will point you in certain diagnostic directions – schizophrenia, bipolar, depression. These categories are presented as natural kinds, despite the fact that the unity of these things remains a vulnerable assumption. While certain kinds of mental disorders might be the right kind of kind to be studied as biomedical disease entities, this does not necessarily imply that this is the only way in which they might be described and lived. To suggest this is not to imply that these categories are wholly arbitrary. Nor is it to suggest the biopsychiatric research is an unworthy pursuit. However, the implicit message that these are essential, discrete, and ahistorical conditions promotes a myopic and depoliticized understanding of these disorders. As a result, these sorts of public health campaigns and anti-stigma programs pass on to those individuals encountering them a depoliticized understanding of psychiatric classifications of deviance and the new kinds of individuals they identify.

These incitements to discourse, the intrusions into our private spaces, and the naming and classifying of different disorders create "*perpetual spirals of power and pleasure*" (HS1, 44-45 emphasis in original). The motivations behind many of our behaviours remain opaque to the untrained eye. Thus it is only once our psychological dispositions, inner thoughts, desires, perversions, anxieties, and compulsions are ferreted out by the professionals, only once they are siphoned through the filters of their expert knowledge do they converge to form a more accurate picture of the kind of person each of us truly is. The experts derive pleasure from the power that qualifies and reinforces their authoritative role. Likewise, the intensity of these examinations lays one's psychological interior bare; one's focus on them intensifies, awareness of them is heightened. Pleasure is felt in transgressing the barriers of silence. Pleasure for the examined might also be derived from knowing that one can manipulate how far and to what extent they submit their psychological interiors for examination. To be certain, this is not only a matter of "pleasure," as construed here in terms of the relationship between the examiners and examined. At the level of the individual, one can hardly deny the sense of relief – of having a name for the problem, of being hailed into the mental health care system that promises some kind of respite from (real) suffering, of being given an epistemic model that explains damaging and stigmatized affects and behaviours. Thus the outward expression and articulation of our interior beings meets with a sort of speaker's benefit, some untoward and others tremendously important.

Conclusion

Collectively, the mass of information comprising the anti-stigma movement, like that encountered on the *Facing Facts* website, creates a discursive web imposing a particularized understanding of, and trajectory upon the experience of one's moods and idiosyncratic behaviours. We are implored to inform ourselves and speak up. Thus while silence is marked as the culprit to be fought, the proliferation of stigma discourses suggests that although certain codes and edicts are to be followed in how and where one speaks of mental disorder, by no means has mental disorder been made speechless. As such, all this talk of stigma creates a performative contradiction in which we speak endlessly about the stigma of mental illness as holding us back from speaking about ourselves as psychiatric subjects, while simultaneously compelling us to speak about our own psychological interiors and emotional behaviours, and sifting these through a psychiatric filter. This speaking up and out does not represent a breaking with the chains of a shaming silence. This speaking is an extension of the very claim that mental illness is silenced at all, the consequences of which entail the immersion of our very modes of being in psychiatric discourse, the laying bare of private spaces for external surveillance, and engaging in processes through which we become new kinds of people, defined by the recesses of our psychological interiors and the deviances that reside therein.

Chapter Three

Biomedical Model of Mental Disorder: Speaker's Benefits

> Millions of Canadians suffering from mental illness could benefit from one simple change. Instead of describing it as a disease of the mind, we need to accept and call it what it really is: a disease of the brain (Dr. Rémi Quirion (n.d.), Inaugural Scientific Director, CIHR's Institute of Neurosciences, Mental Health and Addiction).

> Much of the stigma associated with mental illness is a fear of the unknown. People don't understand that medication works, that those living with mental illness are our families, friends, neighbors and coworkers. …Teaching our children that mental illness is a physical illness affecting the brain and making them aware of potential signs and symptoms will help replace stigma with compassion and encourage them to reach out for help if they should ever need it. (Dr. Gariane Gunter, psychiatrist, crowned Mrs. United States in 2008, who dedicated her reign to working with NAMI to combat the stigma of mental disorder, quoted in NAMI 2008).

In the last chapter, I suggested that anti-stigma rhetoric creates an incitement to discourse, extends the reaches of psychiatric surveillance and classification, and organizes individuals and populations into particular ways of conceptualizing and disciplining the self. I argued that the outward expression and articulation of our interior beings meets with a sort of speaker's benefit in our transgression of the purported stigma hypothesis. These benefits, however, derive not only from speaking about mental disorder, but also from speaking about mental disorder in particular ways. Thus, it is not enough to say that we are incited to speak endlessly about what is wrong with us (the function of chapter two), we must also understand the form and content that speech takes (the function of chapter three).

In this chapter, I present the biomedical model of mental disorder as continuous with and wedded to public health agendas promoting anti-stigma platforms. The language employed in anti-stigma discourse is primarily a biomedical one. This is hardly surprising considering that this literature and its promotional materials often tend to issue from within public health institutions. My intent in this chapter is to fill out in greater detail what the biomedical model of mental disorder actually looks like, and what the rhetorical deployment of its vernacular achieves from the perspective of those who think there is something truth-revealing in its tenets.

Drawing from different neuropsychiatric research in depression studies, I offer a brief overview of what the biomedical model of mental disorder looks like as a functioning scientific paradigm. As a whole, however, offering a precise articulation of how the model functions more generally raises some methodological issues. Given the frequency with which the biomedical model of mental disorder is referred to both within medical practice and popular discourse, one would suspect that the task of characterizing the model would be fairly straightforward – one need simply track down advocates of the model and summarize their positions. Yet, ironically, this is not the case. There is no simple way of referencing the biomedical model of mental disorder in the literature. The biomedical model is routinely referred to as an object of epistemic inquiry. Many refer to it as though it is a fully functioning and determined explanatory model. It is promoted and taken up through the endorsement of such trite statements as "Mental illness is a chemical imbalance," or "Depression is just like diabetes." It is praised by some, and condemned by others. Yet despite the frequency with which it is referenced, this amorphous entity – the biomedical model of mental disorder – is not easily locatable. Rarely is there any formal citation of its defenders.

The irony of this situation is not to be understated. Indeed, it is the impetus behind much of the ensuing discussion. The extent to which the biomedical model has been the object of widespread dialogue and debate, despite the general absence of any staunch advocates endorsing it in its entirety as the primary etiological paradigm, hints that there is something else holding it in place, and pushing it towards the preeminent positioning it is said to hold. I take this irony to suggest that the biomedical model is, in effect, more carved out by external forces than actually defended from within. This may or may not be because at this point in time the model is still just aspirational and not yet fully realized. Either way, as my concern resides with the effects of the model's hidden curriculum, and not with an adjudication of its scientific content and validity, what I try to do is identify the imaginary, or the blank space defined by various cultural forces that assume a biomedical model. I take it as my task to offer a more philosophically robust account of the model (or at least of its origins and effects), wherein I present the model as an emerging historical entity that is at once, a site of scientific inquiry, a source of professional identity and authority, a cultural location, and a hub of economic activity. Offering a full historical account of the relationship between psychiatry and biomedicine is beyond the scope of the project. Rather I aim to point towards the general trends that have contributed to its stronghold. In outlining the spaces and interests that shape and define the contours of the biomedical model of mental disorder, a series of speaker's benefits derived from deploying its vernacular are made apparent.[11]

Biomedical Model of Mental Disorder – "A Style of Thought"

The uptake of the biomedical model of mental disorder is far from complete, and even those most committed to biological explanations of mental disorder generally acknowledge the influence of social and environmental factors. Indeed, contemporary psychiatry tends towards a certain degree of eclecticism, embodied in the biopsychosocial model, which attempts to mediate "the internecine conflicts between biological reductionism and psychoanalytic orthodoxy that characterized most of the 20th century" (Ghaemi 2006, 619). Yet despite this avowed adherence to more holistic models of mental disorder, for various reasons to be discussed, it is the "bio" that seems to carry the greatest rhetorical significance and explanatory power. As a result, mental disorder is increasingly approached as a biological issue, both within clinical research and practice, and the popular imagination (Goldstein and Rosselli 2003, 551).

As Nikolas Rose suggests, biological psychiatry has taken its place as "a style of thought" that not only informs how we understand and relate to ourselves and the world, but has also ushered in with it new sets of scientific and cultural conventions (2003, 412; 2007, 192). Rose argues:

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[11] A version of part of this chapter has been published. Thachuk, Angela K. "Stigma and the Politics of Biomedical Models of Mental Illness." *International Journal of Feminist Approaches to Bioethics* 4.1. (2011): 140-63. Print.

> The new style of thought in biological psychiatry not only establishes what counts as an explanation, it establishes what there is to explain. …In this new account of personhood, psychiatry no longer distinguishes between organic and functional disorders. It no longer concerns itself with the mind or the psyche. Mind is simply what the brain, does. And mental pathology is simply the behavioral consequences of an identifiable, and potentially correctable, error or anomaly in some of those elements now identified as aspects of that organic brain. This is a shift in human ontology – in the kinds of persons we take ourselves to be. It entails a new way of seeing, judging, and acting upon human normality and abnormality. It enables us to be governed in new ways. And it enables us to govern ourselves differently. (2007, 192)

I want to suggest that the effects and force of this style of thought are made most apparent when the external influences circulating around and within the biomedical model are brought into relief. First, the biomedical model of mental disorder can be examined as *a site of scientific inquiry*. The study of the relationships between physiological processes and mental disorders quite obviously plays a pivotal role in the influence of the biomedical model. Operating from within the particularized set of practices and research conventions of the scientific paradigm, the biomedical model functions, secondly, as *a source of professional identity and epistemic authority*. Entire research programs, careers, conferences, and academic journals are built and dependent upon continued acceptance of the biomedical model. In this way, the model is produced, promoted, and sustained from within the medical community and its professional organizations. The biomedical model of mental disorder functions, thirdly, as *a cultural location*. Advocacy groups stake their claims in the model, transforming what it means to have a mental disorder, and in doing so new identities are forged. Finally, it functions as *a hub of economic activity*, wherein monies are accrued and fiscal resources preserved. It is a source of economic wealth for pharmaceutical companies whose products offer hope of a chemical treatment for a biological disorder. It's just like insulin for diabetes. And the ease with which these treatments are administered, in turn, are a panacea for crumbling healthcare systems where cost-effectiveness, overburdened resources, and crowded waiting rooms are looming threats. A detailed examination of each of these influences reveals how, collectively, they shape the contours of the biomedical model, promote its uptake, constitute the interests at stake, and establish it as a style of thought.

Biomedical Model of Mental Disorder qua Site of Scientific Inquiry

In brief, biomedical theories claim that certain (theoretically if not actually) detectable biological substrates lie at the root of mental disorder.[12] These

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[12] As noted by Jerome Wakefield, *concepts* of disorders differ from *theories* of disorder. Theories of mental disorder try to account for the etiological roots or mechanisms that cause disorders. Concepts of mental disorder attempt to define the categorical domain of mental disorder, the content of which varying theories try to fill out (Wakefield 1992, 374). Biomedical theories of mental disorder are closely wedded to biomedical concepts of mental disorder, which postulate mental disorders as objective and scientifically locatable entities. Although all the supporting empirical data may not be currently available, in principle, distinctions drawn between the normal and the pathological can be made immune to the tainting effects of values and normative judgments. In other words, biomedical concepts of mental disorder suggest that, given the full set of facts, psychiatric classification can be value-neutral.

theories generally attribute mental disorder to a deficiency or excess of neurotransmitters, to hormonal imbalances, or to genetic predispositions. In other words, some discrete molecular unit or biological process can be pinpointed (again, theoretically if not actually) as the causal entity. Mental illnesses are not so much problems of the mind as they are diseases of the brain. Brain-based psychiatry assumes that the causal foundations of mental disorders can be objectively identified and scientifically understood. In pursuing these endeavours, biological psychiatry derives its support and epistemic authority from a number of different sciences, including molecular biology, genetics, and psychopharmacology (Garnar and Hardcastle 2004, 365).

Wyatt and Midkiff suggest that "biological psychiatry:"

> describes a phenomenon of increasing visibility in both the professional and popular cultures. It reflects growing acceptance of the notion that chemical imbalances, genetic defects and related biological phenomena cause disorders such as schizophrenia, depression, anxiety, substance abuse, and attention deficit hyperactivity disorder (ADHD). As biological causation has gained attention, acceptance of environmental causation has necessarily declined, and psychotropic medications have become the treatment of choice for mental and behavioural disorders. (2006, 132)

Other interpretive frameworks of mental disorder are adopted in other fields of research, for example, anthropology, epidemiology, sociology, and psychology. Mental disorders are thus not the unique research (or treatment) province of psychiatrists. Nevertheless, as Wyatt and Midkiff suggest above, with this new style of thought, mental pathology is increasingly conceptualized as residing in the organic brain. These organic disorders are what need to be explained, and theories about them are what count as explanations. One of the often cited, more reductionist scholars of biological psychiatry is Samuel Guze. In his classic 1989 paper “Biological psychiatry: is there any other kind?” Guze asserts, “*…there is no such thing as a psychiatry that is too biological*” (Guze 1989, 315 emphasis in original). Guze does not deny that personal experience and/or variances in environment can play some role in the pathogenesis of mental disorder, but from his perspective they cannot fully account for why individuals respond differently to similar circumstances. He states, “I remain agnostic about their ultimate importance because, in the great majority of instances, these putative causes of psychiatric disorders seem to reflect only the usual range of human troubles that most people experience without becoming ill” (Guze 1989, 317). What remains of primary importance is establishing what the differences are in the physiological processes and genetic predispositions of persons with mental disorders. He states, “It appears highly unlikely that an intervention strategy designed to reduce or eliminate the troubles, disappointments, frustrations, and pressures of daily living will prove feasible or powerful enough” (Guze 1989, 317). While trying to figure out how these conditions might be improved is not necessarily inconsistent with a biological perspective, it is the discovery of the physiological variances that contribute to mental disorder that will prove most useful in the development of effective treatment:

> The conclusion appears inescapable to me that what is called psychopathology is the various manifestations of disordered processes in various brain systems that mediate psychological functions. Psychopathology thus involves biology. Biology's scientific strategies are directed at understanding how organisms have evolved and how they develop and function within a genotype-environment framework. (Guze 1989, 317)

Thus for Guze the biomedical model is the rightful paradigm of psychiatric research.

To see how biopsychiatric logic plays out, consider the example of major depression. To be diagnosed with major depression, as classified in the DSM-IV, an individual must experience either a persistent depressed mood or loss of interest or pleasure in daily activities for a period of at least two weeks. In addition to which, during this same time, at least four of the following symptoms must also occur: significant changes in weight, disturbances in sleep patterns, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, difficulty concentrating or making decisions, and/or recurrent thoughts of death (APA 1994). From a psychological perspective these symptoms are generally attributed to negative thought patterns, low self-esteem, an assortment of different personality traits, exposure to trauma, and/or a whole host of other lifestyle factors. Psychotherapeutic treatment generally involves some form of talk therapy. For example, in treating major depression, cognitive behavioural therapy will often engage the individual in identifying his or her negative thought patterns, encourage the individual to isolate those events, people, or situations that trigger one's negative thought and behavioural patterns, and attempt to revise these patterns so that one might respond more positively when presented with similar circumstances in the future. Working from within a psychological perspective does not foreclose the possibility that therapists might agree that depression is caused by a neurotransmitter imbalance, and that talk therapy can be combined with pharmaceutical treatment. What gives weight to classifying practitioners' attitudes as psychologically oriented is placing their therapeutic emphasis primarily on the working through of an individual's past and present behaviour and feelings.

By contrast, from a biomedical perspective, depression is generally attributed to an imbalance in the neurotransmitters, disruptions in neural pathways, and/or genetic predispositions:

> For many years, the prevailing hypothesis of depression has been that a deficit in monoamine neurotransmitters, notably norepinephrine and serotonin, underlies depression. ...This monoamine hypothesis originated in the 1950s with the observation that an antihypertensive medication called resperine depletes the brain of norepinephrine, serotonin, and dopamine, causing depression. (To, Zepf, and Woods 2005, 102)

Contemporary research continues to focus primarily on these three major monoamine systems, however, newer studies have expanded their purview to examine the role of other neurotransmitters, including acetylcholine and gammaaminobutyric acid (Saveanu and Nemeroff 2012, 52).[13] Course of treatment for major depression qua neurotransmitter imbalance primarily entails pharmacological therapy aimed towards increasing levels of monoamine neurotransmitters, whether through regimens of tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), or serotonin norepinephrine reuptake inhibitors (SNRIs).

Certainly, this is a simplified account of the treatment protocols and research findings in the area of depression. Few are likely to support a strictly organic or somatic account of mental disorder, depression or otherwise. Mental health practitioners implicitly hold various allegiances to theoretically complex sets of forces considered responsible for the expression of mental disorders. These factors often include reference to the social, psychological, and biological elements that contribute to mental disorder. “Without doubt, the primary paradigm of psychiatry is the biopsychosocial (BPS) model” (Ghaemi 2006, 619). Nevertheless, despite the fact that most will agree that both environment and biology are contributing factors to major depression, psychiatric research continues to focus on causal models emphasizing the singular role of the brain (Gardner 2003, 108). “A marked asymmetry in research and practice has ...occurred in the past two decades, whereby far more funding, publication, and practice are given to biological/pharmacological approaches” (Ghaemi 2006,

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[13] This trend towards broadening the scope of research is prevalent in other areas of neuropsychiatric research as well. Here too emphasis remains on incorporating other possible biological factors into research agendas. Such features include, but are not limited to, “loss of brain cells, defective ‘biological rhythms,’ abnormal hemispheric lateralization, prenatal errors in brain development, birth trauma, incompatible immune systems between the fetus and the mother, exposure to maternal influenza, slow-acting viruses, and various other genetic factors” (Valenstein 1998, 142-43).

620). In other words, a great deal of the territory continues to be explained in terms of physiological processes.

This preference for biomedical models is evidenced by a number of different studies revealing the biological bias of recent research in the areas of depression and bipolar disorder. For example, a recent analysis of 82 articles on gender and depression, located in a database search in PubMed for 2002, concluded that the biomedical model had “greater prominence” in the literature, when compared to sociocultural and psychological models. This study also concluded that articles adopting a biomedical perspective on depression were less likely to incorporate an analysis of other potential contributing factors. By contrast, those articles coming primarily from a sociocultural or psychological perspective were more likely to take a multifactorial and intersectional scope in their analyses of gender and depression (Hammarström et al. 2009, 692). These outcomes potentially suggest that taking biological factors as one’s object of scientific inquiry restricts from view more holistic perspectives, which take into account the sociological and environmental factors contributing to the pathogenesis of depression.

A similar example of this “biological bias,” is evidenced in a bibliometric study of reports on treatments for bipolar disorder that concluded from its analysis of 100 articles randomly selected from several of the most respected psychiatric journals that “psychopathology and psychotherapies were little cited” (Soldani, Ghaemi, and Baldessarini 2005). In other words, the greatest tendency was to focus on the biological features associated with the aetiology and treatment of bipolar disorder.

These tendencies towards a biological bias and restrictive scope of scientific investigation are not unilaterally practiced. A recent review of more novel research in the area of depression indicates that many new studies are adopting the genetic-environment (GxE) model (Saveanu and Nemeroff, 2012). Melding these two features can be particularly productive, and is quite important given that “Approximately one-third of the risk for the development of depression is inherited, and two-thirds is environmental” (Saveanu and Nemeroff 2012, 52). Research into the pathogenesis and pathophysiology of depression has therefore begun to expand its scope beyond the monoamine systems, in hopes of better accounting for the complexities of depression and its associated symptoms.

This research has broadened in two ways. First, it has expanded its scope physiologically to include analysis of several important regions of the brain (e.g., the limbic system), and the neural pathways associated with them. Much of this research is supported through the use of magnetic resonance imaging to measure changes in the volumes of different brain structures, and the use of positron emission tomography (PET) scans to quantify alterations or disturbances in activity levels in different regions of the brain. Second, this research is also increasingly examining the influences of one’s environment on the brain’s structures and functioning. For example, new research indicates, “…early life stress such as child abuse or neglect occurring during neurobiologically vulnerable periods of development is one of the major means whereby the environment influences the development of depression" (Saveanu and Nemeroff 2012, 57-58). Stress can lead to a myriad of physical changes in the body, including increased secretion of cortisol, which can contribute to the pathogenesis of depression (Saveanu and Nemeroff 2012, 55).

Thus, the body/brain is not always a first cause. Indeed they are thought of as plastic in all sorts of ways. One can believe that depression is caused by a deficiency of certain neurotransmitters, *and* believe that meditation, or exercise, or dietary changes can increase the levels of deficient neurotransmitters in the brain. Novel research into the effects of meditation on the brain's neural pathways is but one example of how the scope and range of research in the area of neuroplasticity is broadening (see, for example, Slagter et al. 2011). Thus it does not necessarily follow from biological reductionism that only pharmacological treatment works.

Not only do these new approaches begin to account for the various influences contributing to depression, but also individual variances in response to different treatment modalities and protocols. For example, some research has indicated that childhood trauma can operate as one of the predictors of individual responses to different treatment modalities (Saveanu and Nemeroff 2012, 63). One study reveals that:

> The likelihood of achieving remission in depressed patients with an early life adverse event was twice as high with psychotherapy when compared to antidepressant treatment and three times as high specifically for those with parental loss. Combination treatment

> was no better than psychotherapy alone. This differential response to treatment suggests that there may be variable neurobiological pathways leading to depression and psychotherapy and pharmacotherapy affect these pathways in different ways. (Saveanu and Nemeroff 2012, 64)

Recognition that not all individuals with depression respond similarly to similar treatments has prompted new research into the effects of various psychotherapeutic techniques on the brain's functioning, gene expression, and the pathogenesis of depression and other mental disorders (Saveanu and Nemeroff 2012, 66). As such, depression is not always categorically best treated with psychopharmaceuticals. Depending on the confluence of factors contributing to its development, other modalities of care might be more therapeutically productive.

Even the most reductionistic of scholars, like Guze, admit that there is more to proper therapeutic care than psychopharmacological treatment (Guze 1989, 320). Nevertheless Guze is careful to distinguish between what he considers to be the respective roles of psychodynamic and biological psychiatric treatment. Guze suggests that the proper role of psychotherapeutic care is to offer "meaning" to one's experiences, and can also be an important means of emotional support, "*but they may have nothing to do with the aetiology of the condition*" (1989, 320 emphasis in original). Psychotherapy cannot shed light on whether the "mental events" talked about are the cause of the disorder, or whether they are the result of the disorder (Guze 1989, 321). In other words, from Guze's perspective, talk therapy cannot offer any insight into the causal relations of psychopathology.

Even if not fully realized at this point in time, biological psychiatry does assume that it can account for some of these causal relations. Numerous studies continue to investigate why it is that persons respond differently to traumatic childhood experiences, through examining why, physiologically, some persons are more resilient than others. While social circumstances, such as familial support, personality, and quality of interpersonal relationships, are factored into resiliency levels, these studies postulate a genetic basis for variances in response to such events. Summarizing the findings of a number of these GxE studies, Saveanu and Nemeroff suggest that, "…the association between the stress of childhood trauma and depression is mediated by a number of neurobiological pathways … and moderated by complex genetic mechanisms" (2012, 62). In other words, there might be physiological factors contributing to one's emotional and enduring responses to traumatic life events. The research presented and reviewed by Saveanu and Nemeroff is thus unique in its explicitly multifactorial perspective. What it does show is that this research can and is being undertaken, and the importance of incorporating a more comprehensive perspective. This is especially the case given the challenges they raise for the widespread pharmaceutical treatment of depression, and that these challenges are posed from within psychiatry's own set of scientific conventions and research protocols and techniques.

To be fair, methodological limitations do impede the ability of any single study to investigate a multiplicity of variables (Gardner 2003, 208). However, as Paula Gardner argues, this concession does not alleviate the problems associated with then taking the findings of research focused on biological factors and, post hoc, pressing them into more complex models of depression that assume environmental factors but do not directly investigate them (Gardner 2003, 111-12). Moreover, divisions of labour within the mental health field are also partially responsible for the apparent polarization between environmental and biological theorists and researchers (Garnar and Hardcastle 2004). While those engaged in more traditional psychotherapeutic treatment are likely to concentrate on the socio-psychological elements of mental disturbance, medical doctors, psychiatrists, and neurochemical researchers are likely to focus on biological elements. These different theoretical models support different research agendas and approaches to treatment. Some might argue that to suggest that "the biomedical model of mental disorder" exists as a freestanding entity is to misconstrue a theoretically interdependent part for the whole of an entirely independent theory. In other words, one might argue that neural researchers and the like do not endorse a purely biomedical theory of mental disorder. Rather, they simply specialize in a singular element of what is in fact a more globally complex and multidimensional model. Most researchers are not as emphatic in their endorsement of the biomedical model as Guze, and will tend to assume (or at the very least theoretically support) a more eclectic approach, with more emphasis placed on psychosocial factors. As I will show, however, for a number of reasons, while such a reductionist approach is rarely maintained to the extent that Guze does, it nevertheless dominates much of psychiatric research and practice. The biomedical model continues to function rhetorically in a very reductive form, which, in turn, informs a broad range of institutional practices. As a result, it is often precisely a simplified and unsophisticated version of the biomedical model that is presented to patients in the clinic and laypersons in the public domain, subsequently strengthening the biomedical model of psychiatry as the predominant style of thought where mental disorder is concerned.

Biomedical Model of Mental Disorder qua Source of Professional Identity and Epistemic Authority

The shift towards a biomedical model of mental illness has not been a linear one, progressing straightforwardly from the superstitious to the biological. Albeit in different forms, theories proposing a physiological basis of mental disorder date back to the time of Hippocrates (c. 460-360B.C.). The naturalistic views of the Hippocratic tradition attributed the causes of mental disturbances to imbalances within the body:

> [Hippocrates'] physiological theories postulated that the bodily fluids, or humors, were the locus of the most salient mental afflictions. An abundance of phlegm yielded the phlegmatic (dull) temperament and personality; accumulations of black bile predisposed one to melancholia (depression); yellow bile was associated with choleric reactions of anxiety, irritability, and troubled dreams; and excess blood was related to mood swings and shifts. (Hinshaw 2007, 58)

Although throughout the centuries brief gestures would be made again towards understanding the structural and chemical features of the brain, it was not until the mid twentieth century (when psychoanalytic approaches dominated psychiatry) that neurochemical theories of mental disorder began to gain any real ascendancy. Yet here too the progression was anything but neat and tidy, and did not involve a simple disavowal of the psychoanalytic for the biological.

During the 1950s psychoanalytic approaches dominated psychiatry in almost all domains. Leading academic and clinical training programs, research projects and funding institutions, as well as the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-I*), were all deeply steeped in the psychoanalytic tradition (Metzl 2003, 38-39). From this perspective, mental disorders were generally conceptualized as rooted in one's early life experiences. Thus it is hardly surprising that the introduction of a number of different psychotropic drugs during this time was met with both scepticism and resistance. Such drugs included chlorpromazine (CPZ), introduced in 1952 for the treatment of schizophrenia (Valenstein 1998, 20-35), the marketing of minor tranquilizers to alleviate anxiety in the mid-fifties, and, in 1957, the introduction of anti-depressants, both tricyclics and monoamine oxidase inhibitors, to the United States' market (Metzl 2003, 98-99).

The introduction of CPZ easily functions as a small local example within the broader historical narrative of psychiatry. This drug illustrates how the introduction of pharmaceutical drugs, coupled with shifting institutional arrangements and support, as well as professional identity crises coalesced to usher in greater focus on biological psychiatry as a mode of research, practice, and treatment:

> At the time, psychiatrists believed that schizophrenia resulted from either a brain disorder or traumatic psychosocial experience. The possibility that a drug could repair a defective brain or undo the effects of life experiences seemed unrealistic and to some, absurd. For psychoanalysts, who believed that the root of mental illness was to be found in repressed wishes, fears, and fantasies in the unconscious mind, the idea of a drug cure was both simplistic and threatening to their most basic tenets. (Valenstein 1998, 20)

Response to CPZ was thus far from optimistic, with one exception. Amongst those working within psychiatric institutions sentiments towards CPZ were more enthusiastic. Here, the effects of CPZ were felt almost immediately as it proved to ease auditory hallucinations and other positive symptoms characteristic of schizophrenia. In these settings, concerns were aligned more with alleviating the immediate distress of patients than with whether or not the use of pharmaceuticals corresponded with one's theoretical convictions. In contrast to psychoanalytic approaches, the underlying issues that might be provoking the symptoms remained of secondary concern. An article from *Time* magazine, printed in 1955, states this difference in priorities quite succinctly:

> The ivory tower critics argue that the red-brick pragmatists are not getting at the patient's 'underlying psychopathology' and so there

> can be no cure. These doctors want to know whether he [the patient] withdrew from the world because of unconscious conflict over incestuous urges or stealing from his brother's piggy bank at the age of five. In the world of red bricks, this is like arguing about the number of angels on the point of a pin. (quoted in Valenstein 1998, 32)

While researchers remained uncertain as to the specific action sites of CPZ, hopes were increasing that the solution to the problems of schizophrenia resided in the brain and not in the revelation of some repressed emotional substratum. Thus despite continued resistance from those operating in the psychoanalytic tradition, eventually several well respected psychiatrists signed on as supporters of CPZ, arguing that other treatments simply could not achieve similar results. Major promotional campaigns extolling its virtues were launched (Valenstein 1998, 21). In 1964, the National Institute of Mental Health (NIMH) endorsed the use of CPZ as a safe and valuable treatment, signalling the first ever, official recognition of the effectiveness of antipsychotic medication (Valenstein 1998, 34).

The NIMH's approval also corresponded with the era of mass deinstitutionalization. With the use of psychotropic medications, it was suggested that many individuals whose psychiatric symptoms were quite debilitating could successfully live within the community. It was argued that the administration of CPZ and other antipsychotics could easily take place outside of the asylum setting, and thus presented a cost effective means of symptom management (Garnar and Hardcastle 2004, 370). Clinical benefits, state endorsed research, pharmaceutical marketing and interests, as well as concern over health costs coalesced to mark the introduction of CPZ as "the beginning of psychopharmacology in the modern era" (Valenstein 1998, 20). The introduction of CPZ renewed (even if incomplete and sometimes reluctant) enthusiasm for brain-based psychiatry, invigorating the search for improved and more specific psychopharmaceutical treatments.

Regardless of this new enthusiasm, however, psychoanalysts still struggled to keep psychotropic medications at arm's length. When these drugs were prescribed, it was often done so under the auspices of enhancing the psychotherapeutic process (Metzl 2003, 42). However, even this brief gesture towards the efficacy of psychopharmaceuticals ultimately worked to undermine the authority of psychotherapeutic practices. Despite attempts to embed their usage within the economy of psychoanalysis, as Jonathan Metzl suggests, "The very need for a product that helped the doctor treat the patient carried with it the a priori assumption that the doctor had not been able to treat the patient before. Psychiatrists could not, in other words, maintain order well enough on their own" (2003, 48-49). Thus throughout the 1950s, despite the stressed importance of psychodynamics within the annals of several prestigious journals, including the *American Journal of Psychiatry*, concern was increasingly mounting regarding the scientific validity and efficacy of psychoanalytic theory, practice, and research, and the lack of consensus regarding even its most fundamental concepts and tenets (Metzl 2003, 43).

By the 1970s, the ever-increasing acceptance of psychotropic medications prompted what Metzl suggests was something of a role reversal between psychiatrists and psychotropic drugs. Where drugs were once the agents of the men who prescribed them, helping them in their clinical practice, now the "medications *became* the men" (Metzl 2003, 50 emphasis in original):

> Throughout the 1970s and 1980s, clinical reports, research articles, and topical papers, often authored by teams of neuroscientists, described the ways in which psychotropic medications performed the actions once carried out by psychotherapists. Tranquilizers, sedatives, antidepressants, and, most of all, benzodiazepines, calmed anxious nerves, made people feel relaxed, allowed for insight, and lifted mood and affect all at once. (Metzl 2003, 50)

In this way, psychiatrists became the handmaidens of the medications, which further eroded their already questionable authority and efficacy qua psychoanalytic practitioners. Thus here we begin to see the conflict and uneasy relationships that the introduction of psychotropic medications precipitated. Those in psychoanalysis and those adhering to biomedical models were each struggling to assert their professional identities, both vying for recognition and scientific authority. Metzl quotes two authors from the April 1977 edition of the *American Journal of Psychiatry* as stating "Psychiatry today faces socio-political, economic, and philosophical pressures that threaten its existence as a valued medical specialty" (Eaton and Goldstein cited in Metzl 2003, 51).

One of the biggest threats precipitating this crisis was the all-encompassing critique launched against the psychiatric institution, its treatments, and practices by the anti-psychiatry movement. Along with a number of other civil rights liberation movements, the anti-psychiatry movement made its entrance onto the scene in the 1960s (Coleman 2008, 344-47). Anti-psychiatrist theorists and psychiatric survivors came armed with severe criticisms of the psychiatric system, calling into question the analogies being drawn between physical and mental disease. Their critiques spanned from psychiatry's definitions of mental disorder to its modes of treatment. Many within this camp argued that psychiatric diagnosis was simply the labelling of socially unacceptable and deviant behaviour, and that psychiatric treatment functioned primarily as a means of social control.

In response to these external critiques and in recognition of psychiatry's faltering status within the field of medicine, attempts were made to streamline the diagnostic process. Shifts were made to focus more directly on observable symptoms rather than those hidden beneath the level of consciousness. It was hoped that a theory-neutral approach to diagnosis, structured along the clustering of specific sets of symptoms, would enhance the consistency of diagnosis, thus undercutting one of the most damaging critiques raised by the anti-psychiatry movement (Hinshaw 2007, 84). This prompted the search for a more standardized approach to psychiatric classification and diagnosis (Hinshaw 2007, 84). "Changes negotiated over the 1970s and culminating in the *DSM-III* (1980), for example, led to a radical removal of the psychodynamic underpinnings of psychiatric diagnosis" (Metzl 2003, 53). The goal was to streamline the diagnostic process regardless of the psychological theory that individual clinicians adhered to.

Yet despite these attempts to remain theoretically neutral and allow for a multiplicity of approaches to psychopathology, contemporary treatment has come to rest primarily in the prescribing of psychopharmaceuticals, wherein the care provider's role is often reduced to promoting compliance with medication regimens (Metzl 2003, 64). As T.M. Luhrmann suggests:

> The psychoanalytic theory of mind will never anymore be understood to provide the explanatory foundation of mental illness, because that foundation, as it is culturally constructed in this age of electron microscopes and genetic analysis, lies beyond personhood, in biological microstructures that escape uniqueness. There is a quality here of the deepest and most real. It has a moral quality: that this knowledge is what really counts, what really makes a difference, what in the end creates the greatest good for the greatest number. …For many young psychiatrists, at least in residency, the moral authority of science outranks the moral authority of helping people one person at a time. (2000, 181)

Thus while the authority of psychoanalytic practitioners was undermined by their increasing reliance upon pharmaceutical treatments (qua psychoanalytic practitioners), the modern shift towards biological psychiatry provides a means of enhancing practitioners' authority (qua biomedical specialists). Today, it is through adherence to the biomedical model and the prescription of psychopharmaceuticals that practitioners maintain their "medical identity" (Luhrmann 2000, 99). In other words, it is what confirms their status as epistemic authorities. Perhaps stated most forcefully by Guze, "…biology clearly offers the only comprehensive scientific basis for psychiatry, just as it does for the rest of medicine" (Guze 1989, 318).

Mental illness is still the object of attention, but what it is as an object has been modified, "… it appears in a new light, with new properties, and new relations and distinctions with other objects" (Rose 2003, 412). It has shifted from the unconscious mind to the organic brain. In turn, this has precipitated a shift in what there is to explain about mental illness and what counts as an explanation. So, too, this new style of thought establishes who is given the authority to do the explaining. The biomedical model of mental disorder surely owes some of its influence to the scientific evidence accumulated in support of its central tenets. However, its current stature is not due solely to its scientific content. Struggles over professional identities and authority were, and continue to be, deeply influential in the shaping of the biomedical model of today.

Biomedical Model of Mental Disorder qua Cultural Location

As Rose suggests, biological psychiatry as a style of thought has ushered in new ways of seeing and explaining. These new ways of seeing and explaining have not only shifted how we look at mental disorder but have also radically altered the way we understand personhood itself. We have become biological citizens, with moods, emotions, behaviours, and even relationships conceptualized in terms of our biology. Certainly, some of this push towards biological accounts of mental disorder and personhood is owed to scientific advances and research.

However, the extent of its explanatory stronghold is also deeply indebted to a number of cultural influences, including a large number of mental health advocacy groups who adopt and promote a biomedical model of mental disorder.[14] Many of these groups embrace this etiological framework as the grounding premise for their anti-stigma campaigns, commonly reducing complex theories to their most simplified forms for the sake of short and provocative sound bites ready for public consumption. These groups contend that likening mental illness to physical illness legitimizes the individual's experience of helplessness, undermines the assumption that those with mental illness are simply weak-willed, and increases accessibility to healthcare services. As Allan Horwitz argues:

> Thus far, in the study of mental disorders advances in neuroscience have mainly resulted in improved psychopharmacology. At this writing, the ascendant belief that 'mental illnesses are brain diseases' is due far more to the cultural belief that only biologically based illnesses are 'real' illnesses than to any empirical findings that the causes of mental disorder are brain-based. The view that real illnesses must have biological causes is, paradoxically, a cultural construction. Advocacy groups lobby for genetic and biological views of mental disorder because if a mental illness is regarded as an organic brain disorder then it is presumably less likely that the individual will be blamed and stigmatized for the

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[14] For a fascinating account of the strategic deployment of biomedical terms by advocacy groups for socio-political ends, see Petryna (2002).

> condition. It is no wonder that people often make prodigious efforts to show that their illnesses are really physical. (2002, 156)

The United States' based National Alliance on Mental Illness (NAMI) is one such advocacy group. NAMI's primary stated goals are to support and advocate on behalf of individuals and families living with mental illnesses, and to educate and raise awareness regarding diagnosis, treatment, and recovery. Since its inception in 1979, NAMI has become one of the most extensive advocacy organizations in the United States with more than a hundred thousand American members, 1200 local affiliates throughout the country, and an information website that receives upwards of 750,000 visitors each month. NAMI is not only most notable for the extent of its membership base, outreach, and political influence, but also for its explicit and emphatic endorsement of a biomedical model of mental illness. Like a host of other advocacy groups, including the National Alliance for Research on Schizophrenia and Depression (NARSAD), NAMI adopts a biomedical model of mental disorder as a central tool in its anti-stigma armamentarium (see, for example, Valenstein 1998, 176–82). For example, until quite recently, the NAMI website stated, "Mental illnesses are *biologically based brain disorders*. They cannot be overcome through 'will power' and are not related to a person's 'character' or intelligence" (NAMI n.d.(a), emphasis added).[15] It currently states, "Mental illnesses are serious *medical illnesses*. They cannot be overcome through 'will power' and are not related to a person's 'character' or intelligence" (NAMI n.d.(b), emphasis added).

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[15] Although this phrasing can still be accessed through a web search, it is no longer the language officially endorsed by NAMI.

This change in phrasing, I suspect, has rather less to do with any fundamental shift in their commitments to a biological model of mental disorder than it has to do with the sorts of criticisms that have been directed towards to the organization as a result of their vocal endorsement of the model. For example, they have been accused of misleading the public and providing misinformation regarding the etiological roots of mental illness. As Elliot Valenstein argues in *Blaming the Brain:*

> While it is important to encourage people who need professional help to seek it out, that does not justify the distribution of biased information and even misinformation. The ads are sometimes carefully crafted to seem balanced, but they clearly leave readers with the message that it has been firmly established that biochemical imbalances cause depression and that drugs are now available to correct that condition. It is not surprising that the pharmaceutical industry finds it in its interest to support groups that are helping it get this message out. (1998, 179)

Thus a second and related criticism has targeted NAMI's involvement with and financial support from the pharmaceutical industry. In fact, in the period 2006-2008 a full three-quarters of NAMI's donations, totalling nearly $23 million dollars, came from drug companies (Harris 2009, n.p.). Moreover, "Documents obtained by The New York Times show that drug makers have over the years given the mental health alliance — along with millions of dollars in donations — direct advice about how to advocate forcefully for issues that affect industry profits” (Harris 2009, n.p.). For the moment, I will bracket larger political questions about the role of Big Pharma in dictating health scientific knowledge and healthcare advocacy in favour of a more local analysis of how the biomedical model is being deployed here. What NAMI’s persistence in this line of attack in the face of such stark criticism reveals is that there are a number of perceived benefits that come from speaking in this language.

First, understood as a biologically based disease, mental illness can then be likened to other biologically based diseases such as diabetes. Once localized in the body the disorder somehow becomes more concrete and tangible, lending credence to the individual’s experience. As the earlier quote from Luhrmann suggests, the etiological explanations that appear the “deepest and most real” are those grounded in biological entities and processes made visible through advances in neuroimaging and genetic analysis. These are the “technologies of psychiatric truth” (Rose 2003, 414). Neuroimaging technologies create pictorial impressions that there are “different kinds of brains,” which in turn are responsible for “different kinds of minds” (Dumit 2004, 6). Advancements in this area have greatly contributed to the perceived truth of mental illness. Their visual affirmation of the reality of mental illness responds to western culture’s affinity for visual proof. Seeing is believing. Thanks to these images we can all, first hand, bear witness to what is going on inside “the depressed brain,” “the schizophrenic brain,” the “bipolar brain.” These technologies entrench the notion that mental disorders exist as free-standing objects of epistemic inquiry, existing prior to and independent of power. They are natural kinds just waiting out there in the world to be identified, classified, and treated by value-neutral scientific enterprises. As Rose suggests, “When mind seems visible within the brain, the space between person and organs flattens out – mind is what brain does” (2007, 198). This process of legitimization influences how others respond to persons with mental illness, and as such, can contribute to stigma reduction.

Second, aside from the obvious financial benefits of NAMI’s ideological affiliations, in advocating a biomedical model of mental disorder, blame is (at least in theory) displaced onto the brain, removing attributions of responsibility from the individual’s family. As with many other advocacy organizations, NAMI was founded by parents of children with mental disorders in response to psychoanalytic blaming of the family unit, and the mother in particular, for the child’s disorder. Much of the work done within NAMI and other organizations of its kind falls under the rubric of what Nikolas Rose refers to as “biological activism,” wherein “one of the key characteristics of parent activism in these areas is to dispute suggestions that the conditions of their children have anything to do with social conditions or parental management” (2007, 216). Because attributions of responsibility are closely linked to the stigma of mental disorder, localizing it in the body ought to (according to this line of reasoning) attenuate the associated stigma, for both the family and the individual.

Third, likening mental disorder to physical disorder reconceptualises it as something beyond the individual’s voluntary control. Displacing responsibility onto the organic brain works to undercut stigmatizing assumptions that persons with mental illness are simply weak-willed or bad characters. For many people, the ability to draw analogies between mental and physical illnesses functions to distinguish what they identify as their "true, authentic, core selves," from their biologically disordered symptoms. In other words, it functions conceptually to distinguish what might be symptoms of a "bad character" from symptoms of a chemical imbalance.

For example, Janet Stoppard and Deanna Gammell found that women describing their experiences of being treated for depression "attempted to separate their 'true' self from their depressed self, the latter of which was seen as weak and shameful. Yet, while women tried to hide their depressed feelings from others, they also wanted others to acknowledge their experiences" (Stoppard and Gammell 2003, 45; see also Schreiber and Hartrick 2002). In this way, the rhetorical deployment of a biomedical model of mental illness accomplishes two mutually reinforcing tasks. First, it creates a framework within which some individuals are able to conceptually maintain, separate out, and reveal what they consider to be their more authentic and in control selves. In this way, stigmatizing attitudes are displaced from the individual onto the symptoms or behavioural manifestations of the illness. In theory, the integrity of one's character remains intact. In other words, it functions as a sort of "medical disclaimer."[16] Second, while it allows for lines to be drawn between the authentic and disordered self, it simultaneously allows for some acknowledgement and recognition of the kind and depth of experiences they are undergoing. Conceptualizing these behaviours and

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[16] One might think that subscribers to the model would think the person is the brain, and is therefore malfunctioning. This attitude does not seem to attach to persons with psychiatric diagnoses, or their close relations. This attitude does reveal itself amongst the general populace, however, when this model is deployed as an anti-stigma tactic. This latter point is discussed in the following chapter.

disorders as involuntary not only works to safeguard the person's integrity, but also creates new pathways of engagement. For if through no fault of one's own one undergoes such painful and frightening experiences, it is truly unfortunate that she must experience such hardship. In other words, this framework of understanding invokes a victim narrative that potentially encourages a more compassionate emotional engagement with one's suffering on the part of others. As Luhrmann suggests:

> From the medical perspective, [the individual's] pain is inessential suffering, it has not made him who he is. It does not come out of the complexities of his past, and it does not lie at the center of his future. This is the great gift of that approach to psychiatric illness. The pain is not your mother's coolness or your father's preoccupation; it is not your disastrous choices, your embarrassments, your inadequacies. The pain is no more you than a winter's cold is. Thus the medical model can rescue someone from stigma, which is a real and horrifying feature of our social life. ...When we learn to empathize through the medical model, we learn to empathize with someone who is a victim of external circumstances, and we are invited to empathize with person as a member of a category of other people: those suffering from depression, from schizophrenia, from floods or other natural disasters. (2000, 275)

In this way, the biomedical model can (at least theoretically) bring tangible benefits to those who speak its vernacular. Given these purported benefits, it is no wonder that many groups advocate for, and individuals with mental disorder rally around, biomedical explanations and promote their uptake.

Biomedical Model of Mental Disorder qua Hub of Economic Activity

As a style of thought, Rose suggests that biological psychiatry enables us to govern and be governed in different ways, and in capitalist societies, how we govern and are governed has economic consequences. As he suggests "Those aspects of life that were previously devalued as pathology, whose humane treatment and welfare was a drain upon a national economy are now vital opportunities for the creation of private profit and national economic growth" (Rose 2003, 415). The circulation of monies within the economy of psychopathology is fraught with irony because on the one hand monies are often withheld on the basis of the stigma of mental illness, while at the same time immense profits are made providing pharmaceutical remedies to mask the symptoms that betray one's stigmatized status. The one consistency is that a biomedical model of mental illness enhances the earnings of almost all involved.

For example, gaps in institutional support and monies are themselves considered to be the result of stigma towards persons with mental illnesses. Thus if mental disorders are neurological disorders that are beyond the individual's control, and neurological disorders are resistant to stigma, then demands are more likely to be met for increased accessibility to and coverage for mental health services (Luhrmann 2000, 250). Biomedical models of mental disorders coupled with advances in the neurosciences are increasingly being used to support mental health service users' demands for parity in insurance coverage, access to treatment, and increased research funding (Tovino 2008, 103–04):

> In a 1987 case out of Arkansas, for example, an insured father sued Blue Cross Blue Shield (BCBS) when it denied additional benefits to his dependent daughter, who had a diagnosis of bipolar affective disorder. The BCBS plan at issue provided liberal benefits for hospitalization and medical treatment for physical illnesses and accidental injuries, but only limited benefits for "mental, psychiatric, and nervous conditions," which the plan did not define. At trial, the father called three psychiatrists and two clinical psychologists to testify that bipolar disorder is a physical disease of the brain. The experts referenced advances in "medical research" to support their testimony that bipolar affective disorder is an illness of the brain that stems from physical and biological causes. The court ultimately agreed that the daughter's illness was a physical condition within the meaning of the BCBS plan, but the victory was short-lived. (Tovino 2008, 106)

Ultimately, BCBS revised its policy regarding coverage for psychiatric conditions. A clause was implemented stating that regardless of whether or not the causal origins of mental illness were biological, coverage restrictions would apply. Although this particular ruling was not long term in its effects, neuropsychiatric research findings continue to inform and hold sway in efforts to reform criminal and civil law, mental health and disability law, as well struggles for parity in health insurance coverage (see, for example, Dumit 2004, 109-33). In this way, these models work to undercut stigmatizing attitudes informing institutionalized discrimination.

Moreover, one cannot deny the obvious benefits of the biomedical model accrued by pharmaceutical companies producing and marketing psychotropic medications. A few empirical examples help put the magnitude of this industry into perspective. During the developmental phase of Prozac, Eli Lilly's initial estimates projected sales in the area of $70 million US dollars a year. Even they themselves as the manufacturers of Prozac could not anticipate that, at its height, Prozac sales would reach nearly $3 billion a year (Goode 2002, n.p.). Worldwide, in 2004, sales from antidepressant prescriptions totalled more than $20 billion US dollars (Raymond et al. 2007, 79). In Canada alone, in 2008, 22.6 million prescriptions for SSRIs were written in Canada, valued at $1.05 billion (Picard 2009, n.p.). This is hardly surprising considering that in British Columbia alone, by 2004, 7.2% of the province's population had filled prescriptions for antidepressants, where "Prevalence of antidepressant use doubled, from 34 to 72 users per 1,000 population, between 1996 and 2004" (Raymond et al. 2007, 79).

Newer psychiatric drugs have since overtaken cholesterol-lowering agents as the best-selling medications in the United States, and in 2009, of the $300 billion sales of all prescriptions drugs in the United Stated, psychiatric drugs totalled $14.6 billion of these monies (Herman 2010, n.p.). In 2009:

> Xanax (alprazolam) was by far the most commonly prescribed psychiatric medication, with a staggering 44,029,000 scripts being written for this psychiatric drug alone. This marks a 29 percent increase in the use of Xanax over the space of four years. …The most astounding growth margin was seen by Cymbalta (duloxetine), which came seventh in the list with 16,626,000 scripts – an increase of 237 percent since 2005. (Herman 2010, n.p.)

A number of complex factors contribute to the prevalence and incidence rates of antidepressant use, including the introduction of new drugs, the lapsing of patents on established drugs, and shifting socio-political climates and arrangements. For the time being, however, the point to be made here is that a staggering amount of money is at stake in the continued acceptance of the biomedical model of mental disorder.

These economic interests also hinge upon the future development of new psychoactive drugs. While it is often assumed that the presentation of new mental disorders precedes the discovery and development of treatments, this is not necessarily the case. Rather in many instances, mental disorders come to be defined in terms of the treatment that is available. In other words, “Medical technology produces medical treatments; medical treatments turn unpleasantness into medical problems; the market puts these treatments up for sale” (Elliott 2003, 194). For example, in the 1950s, drug companies were not enthusiastic about financially supporting the anti-depressant drug industry, as depression was not considered to be of great concern within the broader population. The “fact” of depression had yet to be established. Merck, the manufacturers of the anti-depressant Elavil, subsequently developed and distributed to doctors 50,000 copies of *Recognizing the Depressed Patient*. The impetus behind the campaign was to enhance physicians' ability to recognize the symptoms of depression, and it was successful in its achieving this goal. Where beforehand doctors often said that they rarely encountered patients with depression in their daily practices, now armed with a series of target symptoms, the frequency with which depression was diagnosed was on the increase, so too were prescriptions for Elavil.

In an interview with Dan Fellowes, a retired pharmaceutical employee, Emily Martin questions him about the effects of Merck's campaign:

> DF: Well, first of all Elavil sales just started going right up there through the roof. They passed Tofranil [a competing drug made by Geigy] in about 15 minutes. And then we went back later on and asked general practitioners, ''Do you see depression in your practice?'' They said, ''Oh, frequently.'' We asked, ''Well, how do you recognize it?'' They answered, ''Oh, well, we recognize it by the target symptoms.''
>
> EM: Oh, yikes, so it worked.
> DF: Not only did they feed it back, but they fed it back in the same order we gave it to them in. It was unbelievable. That did two things. Honestly, Emily, it was certifiable proof that effective promotion worked. And that had a tremendous impact on getting a better share out of the promotional budget to do things like that.

> (Martin 2006, 160-61)

While these sorts of promotional activities are often the targets of criticism, for those working within the industry at the time, these actions were contextualized within the moral economy of altruism (Martin 2006, 158). Frank Ayd, an M.D. and researcher for Merck in the 1950s, and also the developer of a film which accompanied *Recognizing the Depressed Patient*, said he felt "like John the Baptist …out preaching what's coming", and what was coming was a "blessing for mankind"(Ayd quoted in Martin 2006, 157). This sense of "helping those in need" is no less the case today where pharmaceutical representatives suggest that direct to consumer advertising functions as a form of education that not only enhances consumer empowerment, but also reduces stigma and encourages help-seeking behaviours. Once individuals know that there are solutions available for what might feel like shameful problems, they will be less concerned about speaking with doctors about possible treatment options (Martin 2006, 166-71). Whether or not this is the case, one cannot reasonably deny that the primary impetus behind these promotional campaigns is to enhance pharmaceutical sales. At stake here are the economic interests of a variety of groups in terms of profits and investments, research funding and the incomes of individual doctors. The consolidation of these interests is a mass industry whose existence is contingent upon acceptance of biomedical paradigms of mental illness and their attendant diagnostic labels.

Finally, in marketing mental illness as an objective entity residing in and caused by the diseased brain, pharmaceutical treatment is subsequently seen as the most logical and effective form of therapy. Paula Gardner argues that epidemiological studies regarding depression or mental illness in the United States "consistently link mental illness with personal and State economic productivity, suggesting that the State embraces biopsychiatry to ensure a productive economy" (2003, 108). Emphasis on the biological foundations of mental illness, removing attributions of responsibility from the individual, allows the promotion of pharmaceuticals on behalf of the state (Gardner 2003, 109). So too does this shift remove attributions of responsibility from the state. In other words, if the problem is an organic one, then neither the individual nor the state need be held accountable for the onset of mental disorder. In turn, the individual becomes responsible for the offset of the disorder through compliance with pharmaceutical regimens, implying that larger social conditions need not be examined.[17]

Thus the financial benefits of the biomedical model of mental disorder are immense. It can enhance the availability of neuropsychiatric research funds, increase accessibility to insurance coverage (for certain modalities of care), vastly augment the profits of pharmaceutical companies, and relieve the state of more costly measures to improve the mental health of its population.

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[17] Certainly this is not unilaterally the case. For example, post-traumatic stress disorder (PTSD) is increasingly recognized as endemic within certain occupations. As a result, different organizations are being held at least partially accountable for their role in these injuries, as well as being called to take responsibility for treatment and compensation for those afflicted. A series of interesting articles on this were recently published in *The New York Times*, criticizing the State's lack of proper care for returning veterans suffering from PTSD. See, for example, Kristof (2012).

Conclusion

In theory, then, this explanatory model adds legitimacy to mental illnesses as concrete, stable entities of inquiry and categories of experience, aids in separating out the illness from the true person, cultivates compassion for those suffering from circumstances beyond their control, increases accessibility to adequate health care coverage, challenges institutional discrimination, and supports faltering healthcare and economic systems. In many respects biomedical models can (at least theoretically) prove beneficial in dispelling certain elements of the stigma associated with mental illness. As such, there are benefits to be enjoyed by those who situate themselves and speak from within this particular frame of reference.

However, as I have shown, contrary to the way it is presented to and understood by the public, the biomedical model is as much a product of its socio-economic cultural uptake as it is of its scientific content. It is perhaps not so much what lies within the model that gives it its form, pushing outwards and creating its contours, so much as external forces that give it its shape and texture. Indeed, as "a style of thought" the model's scientific context is itself another product and example of its socio-economic uptake. That is, only once the model gains any real ascendency does it begin to determine how research is to be done, what is to be researched, and, indeed, what does and does not count as knowledge itself. Thus whether or not the findings of scientific research remain inconclusive, as a style of thought, biological psychiatry has very real consequences, and a broad array of benefits and detriments for those speaking and spoken about within its terms.

Chapter Four

Biomedical Model of Mental Disorder: Speaker's Detriments

> The logic was straightforward. Behind every thought or feeling, there was a molecular reaction in the brain. Behind every molecule in the reaction, there was an enzyme that created the molecule; behind every enzyme was a gene.
>
> If the gene was defective, the enzyme would be defective; if the enzyme was defective, so would be the molecule; if the molecule was defective, so would be the chemical reaction and so, inevitably, would be the thought the reaction produced. Or, as one scientist simplified it, in a few words with many levels of meaning, "Twisted molecules lead to twisted thoughts" (Jon Franklin cited in Dumit 2004, 147).

Anti-stigma rhetoric creates an incitement to discourse and compels us to speak in particular ways. As argued in the last chapter, this discourse and the benefits derived from it are, by and large, wedded to a biomedical model of mental disorder. What advocates of this model generally do not acknowledge, however, are the series of detriments incurred by those who speak and are spoken about in these terms. In this chapter, I offer a critical analysis of the strategic deployment of biomedical models of mental illness in order to provide an alternative lens for re-rereading the model's purported benefits, thus laying the groundwork to mount a counter-discourse. I illustrate the detriments of the biomedical model, understood here, as in chapter three, as a site of scientific inquiry, a source of professional identity and epistemic authority, a cultural location, and a hub of economic activity. My intention here, then, is not to contest the scientific findings of neurobiology as such, but rather to tease them apart from the political ends that animate their research.

To begin, I examine the detriments of the biomedical model as a site of scientific inquiry. I illustrate how the increased emphasis on biological vectors obscures from view the larger social conditions that contribute to the incidence rates of mental disorder, shape its outcomes, and stigmatize its behavioural manifestations. As a result, psychopathology is depoliticized, and constructed as a problem of the individual. Second, given that the biomedical model promotes particular ways of thinking about mental disorder, it necessarily inscribes the authority and legitimizes the expertise of particular sets of professional experts to oversee and treat psychopathology. The wedding of anti-stigma campaigns to biomedical models directly promotes the social credibility of the psychiatric profession. This gives reason to question the motivations behind professional and institutional endorsements of the biomedical model of mental disorder as an anti-stigma strategy. Third, drawing from a body of empirical research, I detail the untoward effects of forging identities around the biomedical model of mental disorder. This literature reveals how biomedical models promote beliefs that persons with mental disorders are of a different kind, are dangerous and untrustworthy, and precipitates new forms of iatrogenic stigma, resulting from medical diagnosis and treatment, and/or interactions with or activities of medical practitioners. Finally, given the economic interests at stake in the continuance of the biomedical model, other forms of care or treatment are either not made available or are not accessible except to those with the means to finance such options. Likewise, the entanglement of the pharmaceutical industry with leading mental health advocacy groups reveals how some drug companies are deploying the rhetoric of stigma to further their own financial interests.

By way of concluding, I argue that while biopsychiatric logic is enabling in certain respects, its strategic deployment is also politically dangerous. My alternative reading of the biomedical model as a style of thought suggests that collectively they function less to support persons with mental disorders (their purported aim) than they do to 1) minimize the responsibility of the state to respond to the larger social conditions of its population, 2) enhance the professional identity and epistemic authority of designated biopsychiatric experts, 3) introduce new sets of misperceptions damaging to persons with mental disorders, and 4) allow the financial interests of the state, insurance companies, and pharmaceutical conglomerates to govern treatment options and coverage.[18] Detailing these detriments is a curious task, for it is often precisely those benefits garnered from the vernacular of biopsychiatric logic that in turn are also its detriments. This chapter, then, illustrates how the rhetorical discourse of the model is at once both enabling and constraining.[19]

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[18] While perhaps these consequences are not all on equal footing, each influences how mental disorder is understood, and persons with mental disorders responded to. As such, I do not rank them in any specific order as they function as a collective unit that can only be artificially parsed down to its discrete elements. Doing so would risk fragmenting the broader context within which anti-stigma discourse operates, and makes its effects felt.

[19] A version of part of this chapter has been published. Thachuk, Angela K. “Stigma and the Politics of Biomedical Models of Mental Illness.” *International Journal of Feminist Approaches to Bioethics* 4.1 (2011): 140-63. Print.

Biomedical Model of Mental Disorder qua Site of Scientific Inquiry

As the dominant style of thought, biological psychiatry sets in place particular research agendas, highlighting some areas of focus as more worthy of pursuit than others. As illustrated in chapter three, a great deal of work in biological psychiatry currently concerns itself with the interactions between individuals and their environments. These sorts of studies can be more or less holistic in their approaches, and, as suggested, their ability to begin localizing the specificities of interactions between individual life histories, mental disorder, and responses to various therapeutic modalities bring with them a whole new range of perspectives that are potentially quite illuminating and can be put to a number of alternative and enabling ends. These are the benefits of this site of scientific inquiry.

Nevertheless, despite these benefits, a troubling form of reductionism continues to underwrite genetic-environment (GxE) research agendas. While there is an avowed adherence to a more comprehensive approach to mental disorder within this field, primary emphasis continues to rest upon locating the postulated genetic differences that are thought to account for individual variances in response to similar traumatic events or difficult life circumstances. For example, recognition might be paid to high rates of histories of child and/or sexual abuse amongst persons with mental disorders, but, from this perspective, these incidence rates are not what need explaining. Rather, what needs to be explained, is why individuals respond differently in the face of similar events. Invariably, the answer seems to reside in the afflicted individual's body.

Certainly the claim that mental illness is internal to the material body of the individual does not by itself rule out the possibility that conditions external to the individual have influenced the biological processes internal to her. As suggested, novel research in the area of neuroplasticity is being conducted that attempts to locate the effects of one's life experiences or activities on the pathways and anatomical structures of the brain. Even Guze admits that continued research into risk and resilience factors external to the individual is not inconsistent with the research agenda of biological psychiatry. Nevertheless, it is the biological components that retain explanatory power. As Garnar and Hardcastle suggest, "While biological psychiatry might not start with the brain, the assumption is that there is nonetheless something ontologically and epistemically foundational about it" (2004, 367). Brain imaging technologies, psychiatric genetics, and psychopharmacology all contribute to the localization of mental disorder in the body's interior (or even more narrowly within the brain) rather than within the individual's personal history, character, or within the environmental, economic, or psychosocial geographies the individual inhabits. Clearly our memories, emotions, and patterns of reaction are caused by what happens in our brains, which in turn is also influenced by what happens in our lives. Nevertheless, overemphasis on the biological underpinnings of mental disorder promotes individualistic understandings of how it is best treated.

This tendency reassembles mental disorder in such a way that deflects attention back onto the individual's body as the determining factor in the development of mental disorder. Rather than encouraging a critical analysis of the social conditions in which incidence rates of mental disorder are increasing at a staggering rate, within psychiatric research, emphasis is placed on the establishing the physiological risk factors that are thought to account for individual responses to these conditions. These risk factors are sometimes not known until they manifest as symptoms. The point of genetic-environment research is to make these risk factors visible. The individual becomes the basic unit of observation or object of epistemic inquiry (Tesh 1988, 161), the end result of which prompts individualistic solutions.

Yet the influence of these external factors cannot be overlooked. Consider, for example, the role that sex differences and gender roles play in mental disorder. While in Canada the prevalence of mental disorder amongst males and females does not vary to any great degree (11% of women and 10% of men [Salmon et al. 2006, 8]), the incidence rates of particular diagnoses and the forms of treatment prescribed vary differentially by sex:

> Women are twice as likely as men to be diagnosed with depression and anxiety. Women are also more likely than men to be prescribed an SSRI medication for a diagnosis of depression. Recent Pharmanet data from BC show that 19% of women (nearly 1 in 5) over the age of 30 received at least 1 SSRI prescription between August 1, 2002 – July 20, 2003. Women accounted for 66% of physician office visits for depression in Canada in 2004, and 81% of such visits for depression resulted in a prescription for an antidepressant medication. (Salmon et al. 2006, 15)

Further to this, a study by Cormier et al. suggests that:

> Women [are] twice as likely as men to have benzodiazepines prescribed to them for "non-clinical" symptoms, such as stress from work or home life, grief, acute or chronic illness, physical pain or adjustment to a major life change, and to have them prescribed for longer periods. It is becoming clear that women are over prescribed benzodiazepines to cope with difficult life circumstances rather than to relieve severe clinical symptoms. (2004, n.p.)

Thus overemphasis on physiological risk factors obscures the real complexities at play. It does not speak to diagnostic and treatment differences, nor does it speak to the social conditions, "the difficult life circumstances," that contribute to these differentials. These statistics point to the fact that reliance on pharmaceuticals is increasingly the tactic pursued to enable individuals (women) to cope with difficult life circumstances. In these statistics one cannot help but hear echoed Guze's sentiments that energies are more gainfully employed in developing pharmaceutical treatment, as "It appears highly unlikely that an intervention strategy designed to reduce or eliminate the troubles, disappointments, frustrations, and pressures of daily living will prove feasible or powerful enough" (1989, 317). The research agendas and practice protocols that develop out of this sort of reductionism are deeply problematic.

Consider, for example, that for many women with serious mental illnesses, these "difficult life circumstances" and "troubles, disappointments, frustrations, and pressures of daily living" include a history of "various forms of intimate violence, that is, physical, sexual, emotional and verbal abuse as children or adults" (Morrow 2002, 5), and their vulnerability to violence increases as their health deteriorates (Morrow 2002, 3). A survey of women at the Riverview Psychiatric Hospital in British Columbia found that approximately 58% of these women had been sexually abused as children, while elsewhere another study showed that "when both physical and sexual abuse were taken into account, …83% of women in an inpatient setting had had these experiences" (Morrow 2002, 6). While it remains underdetermined whether there is a direct causal link between violence and mental illness, the strength of the correlation is enough to suggest that the issue of violence cannot be overlooked. As Sylvia Noble Tesh suggests, "If a possible toxic substance contaminates the water or air, it is not a neutral act to leave it there" (1988,171). Thus where research energies are focused is not a neutral act resulting from objective decision-making regarding the parameters of a specified field of inquiry. It is inherently an ethical decision, and one that has a profound impact one how this translates into clinical care.

Despite these findings, within a biomedical framework, the influence of violence in these women's lives continues to be overshadowed or made secondary to diagnostic classification. "The manifestations of abuse on the body or the mind, lie within the medical gaze; a 'fractured arm' or 'depression,' for example, are the diagnoses made. But what is occluded is the social context: the abuse in women's lives, the cause of these injuries" (Bell and Mosher 1998, 216). In turn, responsibility for recovery is left to the individual (often in the form of adherence to a regimen of psychopharmaceuticals) rather than encouraging any grander challenge to the social institutions that contribute to women's oppression (Sherwin 1992, 85). Thus while the biomedical model of mental disorder removes attributions of responsibility from the individual for the onset of the disorder, it simultaneously and paradoxically puts the onus for recovery back on that same individual.

As Tesh suggests, there are two very different sets of questions that can be asked in determining approaches to public health policy, one structural, and the other individualistic (1988, 163). On the one hand, one might ask, why it is that large numbers of people experience mental disorder? On the other hand, why it is that these particular individuals experience mental disorder? Answers to the first question bring into relief the structural conditions that potentially contribute to the development of mental disorder – political and economic climates, influence of direct to consumer advertising, gendered divisions of labour, social supports or lack thereof, and a whole host of other contextual features. Answers to the second question will more directly concern the psychology and physiology of individuals. Clearly, genetic-environment research tends towards the latter in directing its energies towards establishing its more narrow concern with why some develop mental disorders while others do not. It is more localized, concerned with the individual and his or her particularities. "Prevention concerned solely with these individuals conceals an endorsement of the structure" (Tesh 1988, 163). These individualizing tendencies lead to a situation in which structural conditions are taken as given and "unfeasible" to challenge, and result in equally individualistic solutions.

These individualizing tendencies are then often translated into the operating discourses of policy and governmental directives and programmes. Kathy Teghtsoonian's analysis of a series of documents on depression and mental health literacy produced by the Liberal government of British Columbia following their election in 2001 clearly illustrates this (2009). She argues that the documents under question, namely *British Columbia's Provincial Depression Strategy* (2002) and *Development of a Mental Health and Addictions Information Plan for Mental Health* (2003), implicitly suggest that depression is a problem of the individual. Brief gestures are made towards the social factors that are likely contributing to the rising incidence rates of depression in British Columbia. However, it is primarily the role of the individual that remains the focus of the discussion, while leaving aside questions concerning the extent to which the current shifts in economic and political climates can negatively impact the mental health of the population. "Instead, the explanatory focus is on knowledge and information gaps that leave individuals unable to identify the presence of depression and/or likely to make ineffective or inappropriate choices regarding treatment" (Teghtsoonian 2009, 31). In other words, armed with the proper knowledge and information *individuals* can more readily recognize problematic symptoms and seek proper care.

Thus, while the individual is relieved of responsibility for the onset of mental illness, she is simultaneously positioned to assume responsibility for early detection and/or prevention, and to enact the role of rational consumer in the treatment choices made on the road towards recovery. To a certain degree, this represents a positive shift in terms of restraining some of the overtly paternalistic practices within psychiatric care. Nevertheless, because we lack vision into and understanding of our internal brain processes we may come to think of our brains as latently mentally ill. Concomitantly, a whole new range of risk-assessment and self-management tools, and technologies of governance are introduced, streamlining individual choice and behaviour in accordance with the state's sanctioned goals.

How this research gets translated and put into use in the public domain is problematic. While this might be more a feature of its application than a fault with the science itself, one cannot easily (or even desirably) separate scientific fact from the political ends it may be used to support. Although, as I previously argued, there are limitations to what can be incorporated into a single study, and different fields are concerned with different areas of exploration, one can still call into question the effects of these research agendas that promote such reductionist perspectives. In one and the same rhetorical move, the displacement of responsibility onto the organic body removes responsibility from both the individual *and* the state. Once positioned as internal to the individual, the state averts being taken to task to alter the institutional arrangements and social conditions detrimental to the mental health of its populace.

The individualizing tendencies of the biomedical model of mental disorder thus wed neatly to the nexus of individualism in western culture, which Tesh argues allows for health policy makers to adopt the least politically disruptive courses of action (1988, 160-67). Grounding deviance in physiological processes impedes challenges to the socio-political norms and context that define and make possible the pathologization of certain types of behaviours and modes of being. Attention is drawn back towards the body marked as other, the brain marked as broken, and away from those social vectors that may precipitate mental disorder and seriously shape its trajectory. Focus is placed on re-fashioning the objective material body rather than modifying the systemic factors that contribute to the health conditions of a given population. These individualizing tendencies leave structural conditions unquestioned, taking them as natural givens. As such, they fail to effectively target those social structures and political alliances that influence the stigmatization of mental illness. Mental illness is thus depoliticized, draining the power out of critical analyses targeting dominant institutional knowledges and practices, and treatment protocols.

Biomedical Model of Mental Disorder qua Source of Professional Identity and Epistemic Authority

As a style of thought, the biomedical model of mental disorder establishes what there is to explain about mental illness, what counts as an explanation, and who gets to do the explaining (Rose 2007, 192). Within this paradigm, medical practitioners in general, and psychiatrists in particular, are logically designated as both the gatekeepers and guardians of mental disorder. Through its alignment with the research conventions and technologies of the scientific paradigm, psychiatry has gone some distance in advancing its knowledge base and improving its standing in the public eye. While these benefits are not to be denied, I want to suggest that psychiatry's increasing emphasis on biological processes, neuroimaging, and psychopharmacology has impeded critical consideration of the costs involved in the continued enhancement and maintenance of its professional identity and epistemic authority. I argue that however well intentioned psychiatry might be in its movement on an international level to target stigma both amongst the lay public and members of its own profession, this involvement cannot be disentangled from its own interests. That is to say, the movement to target stigma from within the psychiatric profession cannot be made separate from the ideologies and interests that make possible the construction of mental disorder qua biological disorder as an object of knowledge.

As I argued in chapter three, the institution of psychiatry has gone to great lengths to secure its professional identity through its alignment with the scientific practices of biomedical research, diagnostics, and treatment. This has meant the promotion of a particular way of understanding mental illness that represents the considered and agreed upon way of thinking. In order to ensure the continuance of this style of thought, dissension surrounding the facts of mental illness needs to be minimized. This is not to imply a sinister sort of conspiratorial silencing, although certainly there are elements of this present in the pharmaceutical industrial complex, a point I will be addressing shortly. For the time being, however, what I want to highlight is the need, within the profession itself, to create and sustain the impression that there is some general consensus surrounding the concepts of mental disorder, and standardized approaches to diagnosing and treating it. In many respects, this is simply an extension of earlier moves to create a sense of unity in the field wherein the DSM was revised in order to streamline diagnostic processes and categories of identification. Related to this is also the goal of minimizing the knowledge gaps between public opinion and received views of mental disorder. Thus there are two separate levels of consensus building to take into consideration. The first is to present the field of psychiatry as a unified front. The second level is to create consensus between this front and public perceptions of mental disorder. These two levels of consensus are symbiotically achieved, in part, through professionally sponsored and endorsed anti-stigma initiatives.

These two levels of consensus building, and the professional interests underwriting them, are reflected in the *Changing Minds* anti-stigma program of the Royal College of Psychiatrists in Britain. A major goal of the *Changing Minds* campaign, like numerous others, is to emphasize the prevalence of mental disorder in order to make it seem more commonplace and unremarkable. Consensus statements are provided as educational tools on a number of different disorders, each of which "review stigmatizing fears and their attendant facts, aetiology, treatments, and the resources society should provide to deal with the disorders effectively" (White 1998, 509). The presentation of these consensus statements, however, implies that the facts of these disorders have been established. In their analysis of this initiative, Pilgrim and Rogers argue that:

> At no point are the notions of 'mental disorder' or 'mental illness' problematized by the campaign – quite the reverse. The campaign

> is used as a vehicle to create a sense of certainty on behalf of the profession and for its audience about the nature and frequency of 'mental disorders.' (2005, 2551)

Mental disorders and their diagnostic categories are thus reified as natural givens existing prior to the social relations that make possible their classification and stigmatization (Pilgrim and Rogers 2005, 2550). The catchphrase, "the stigma of mental illness," suggests that there is something concrete and enduring in the world, namely "mental illness," around which a great deal of stigma circulates. Attention is thus directed away from questioning the terms of reference themselves, for example, the extent to which the category mental illness itself is problematic and contributes to the stigmatization of diagnosed persons, or even whether stigma is the appropriate analytical lens.[20]

In accordance with this move, another of the campaign's stated goals is "…to close the gap between the differing beliefs of healthcare professionals and the public about useful mental interventions" (Royal College of Psychiatrists cited in Pilgrim and Rogers 2005, 2548). Energies are thus aimed towards promoting public mental health literacy. The problem is one of educating laypersons in accordance with the considered understandings of the profession. As an anti-stigma tactic, the desire to close the knowledge gaps is premised upon the assumption that if the public only knew enough about mental disorder it would

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[20] Some have argued that *discrimination*, in contrast to *stigma,* more adequately describes the processes at work in the social marginalization of persons with mental disorders (see, for example, Sayce 1998). Stigma keeps our gaze directed towards the person marked as other, whereas discrimination refocuses attention on the external social and political context and institutional arrangements that make possible this marginalization. For this reason, discrimination, I agree, is a better term.

change how they affectively engage with those identified as mentally disordered. If the range of competing views and ignorance about the nature of mental disorder is minimized then so too will the stigma associated with it.

The presentation of this information as a means of targeting stigma, however, involves an interesting slight of hand. A particular set of knowledge is offered up as the accepted view of mental disorder. The suggestion is then made that misperceptions regarding mental disorder (i.e., those that do not conform to the accepted view) are responsible for the continued stigmatization of persons with mental disorders. Stated otherwise, if you don't educate yourself, then you're part of the problem. Couched within this sort of rubric, people are less likely to adopt a critical stance towards the information presented to them, as it is often difficult to resist or position oneself in opposition to such mass scale efforts to improve the lives of others. Indeed, the very suggestion that there is something problematic with these anti-stigma campaigns as a whole is, at times, like walking a tightrope between recognizing the value and successes of these initiatives, and exposing their more subterranean and repressive effects. Thus I suspect there is something to the emotional pull embedded within these calls to better the standing of persons with mental disorder that makes the uptake of the information presented within these campaigns more fluid and complete.

Again this is not to entirely undermine or condemn the advocacy efforts of these organizations, professional or otherwise. Rather the intention is to highlight the interests that underwrite the rhetoric of stigma reduction. Psychiatric labelling and treatment have long been criticized for their damaging consequences both in terms of self and social stigmatization. It is perhaps, then, debatable whether or not the negative effects of these labels can be assuaged within the very same terms of reference that precipitate them (Pilgrim and Rogers 2005, 2552). So too we might want to question the extent to which these professionally driven campaigns might be more properly understood as tools targeting the stigma associated with *psychiatric labels* rather than tactics to dismantle the stigma of cognitive and affective *difference*. These anti-stigma campaigns often seem to suggest that there is consensus about what mental illness is and how best to treat it, when, in fact, the answers to these questions are underdetermined. The effects of this, however, potentially promote one perspective at the expense of alternative approaches to mental disorder, and at the expense of different relationships individuals might construct in relation to cognitive and affective difference.

Biomedical Model of Mental Disorder qua Cultural Location

Changing social attitudes and behaviours takes time, and the contemporary global mental health movement is a fledgling one. Given its relatively short history, Kimberley White suggests that stigma-busting initiatives, like that of the Mental Health Commission of Canada, are moving forward "in relative empirical darkness around the impact and effectiveness of anti-stigma campaigns" (White 2008, 3). Within this darkness, however, exists are fairly wide body of literature suggesting that the biomedical model of mental disorder potentially contributes to and reinforces the very stigma it seeks to dismantle (see, for example, Corrigan et al. 2005; Goldstein and Rosselli 2003; Mehta and Farina 1997; Phelan 2002; Read and Harre 2001). In fact:

> …by 1961 this approach [the biomedical paradigm] had been deemed a failure, by the US Joint Commission on Mental Illness and Health: 'The principle of sameness as applied to the mentally sick versus the physically sick… has become a cardinal tenet of mental health education…. Psychiatry has tried diligently to make society see the mentally ill in its way and has railed at the public's antipathy or indifference' (p.59). Then, as now, the failure was located in the ignorance of the public rather than in the validity of the principle. (Read and Harre 2001, 224)

Thus again and again we hear echoes of the processes of individualization present in the mental health promotion documents of the British Columbia Liberal government and Britain's *Changing Minds* campaigns. Individuals fail to understand mental disorder, and how it ought to be treated, and consequently they do not know how to respond to persons so diagnosed. Nevertheless, despite cautionary notes regarding the deployment of the biomedical model as an anti-stigma tactic, advocates of the model, like NAMI, continue to endorse its basic tenets. To be fair, the model does correct certain misperceptions of persons with mental disorders, and perhaps it is unreasonable to expect the campaigns to have already made more progress than they have. At the same time, however, given what the available research does suggest, we ought to be sceptical of including the biomedical model in our anti-stigma armamentarium. While it might reduce some stigmatizing perceptions, it promotes others -- some directly related to, and others more distally related to, issues of responsibility. Within the stigma literature, three of the most commonly discussed drawbacks of biomedical models include: 1) their reinforcement of notions that persons with mental disorder are of a fundamentally “different kind,” 2) their entrenchment of beliefs that persons with mental disorder are untrustworthy and dangerous, and 3) their promotion of psychiatric labelling and pharmaceutical treatments, which some argue further stigmatizes and disempowers mental health service users.

First, the advancement of medical imaging technologies has worked to visually confirm the reality of some mental disorders at least some of the time. These images have been deployed to establish their status as fixed entities of inquiry and experience. In the social imagination, colourful PET scans have become the precondition for establishing the scientific objectivity of the biomedical model of mental illness. “Increasingly, the managed image has become the precondition of sight: the sunset has become as beautiful as the picture postcard” (Duden 1993, 17). Concrete visual representations of the brain’s inner activities and functional processes provide a foothold for the evidentiary value of biomedical models of mental disorder.

The use of photographic images is not something novel to contemporary scientific culture. In fact, the “managed image” has long been deployed in psychiatric research and practice. For example, in 1891, Pitres featured a series of photographs of Albert Dadas, the first diagnosed fuguer, to visually illustrate how different he appeared in four different cognitive states.[21] "It was urged in many quarters that photography introduced true objectivity into science. No longer did we have to rely on artist's impressions or verbal reports" (Hacking 1998, 19). Likewise, the author of Merck's *Recognizing the Depressed Patient,* Frank Ayd, produced a film to accompany the booklet. This film featured outtakes from the psychiatrist's clinical practice in order to help physicians distinguish depression from anxiety, for example, on the basis of facial expression and posture (Martin 2006, 160). As such, the suggestion that neuroimaging makes mental disorder visible for the first time is misguided. Rather this suggestion speaks more to the dismissal of the epistemic value that once attached to photos such as those taken by Pitres and films like that of Ayd. While once these photos and films were thought to reveal something medically significant, today it is the colourful images of brain sections captured by neuroimaging technologies that we construct as truth-revealing. These technologies make the invisible visible, the interior exterior.

What sorts of effects do these images have when colourfully displayed in the pages of popular magazines? One of the earlier examples of PET scan images in popular media, occurred in July 1983, in a Vogue magazine article which presented three vividly coloured images of varying patterns, each respectively labelled NORMAL, DEPRESSED, and SCHIZO (Dumit 2004, following 161, PLATE 1.). In his analysis of this article, Joseph Dumit asserts:

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[21] Dissociative fugue is a rare condition that involves unexpected travel or departure from one's daily life. During this period of time, which can last from hours to several months, the individual is unable to recall some or all of his or her past and identity.

> …together [these images] argue that there are three different kinds of brains that correspond to three kinds of brain images. Because the images are clearly so different from each other, they make the additional argument that each brain kind is easily distinguishable thus diagnosable through a PET scan – a diagnosis of schizophrenia, depression, and even normalcy. (Dumit 2003, 36)

This visual repertoire thus allows for a series of categorical errors -- "The Bipolar Brain," "The Schizophrenic Brain," "The Broken Brain,"-- ingraining in the social imagination what seem to be clear demarcations between the "mentally ill" and the "non-mentally ill" (Dumit 2003, 37).

Such images have since proliferated in popular media. Thus by now, most people in western culture are at least superficially acquainted with the brain as an object of scientific inquiry, and are familiar with the metaphors used to describe it (Dumit 2004, 141). As a result, in many instances, in encounters with PET scan images, "the image overtakes the text, overturning the authority of the text" (Dumit 2004, 143). In other words, the images are no longer illustrative of what the accompanying textual passages speak; rather the images themselves become the "central argument."

Even if the textual passages are given careful consideration, as Dumit argues, the presentation of these images in popular media and the textual referents accompanying them, "may be far removed from the careful conclusions of the original scientific journal article, and the news story may include comments deemed 'indefensible' by the original researchers" (2004, 7). Neuroimaging researchers and experts agree that brain scans cannot diagnose mental disorders (Dumit 2004, 111). Likewise, while differences in brain patterns may correlate to different mental conditions, researchers generally concur that it does not necessarily follow that these variances are the causal root of such disorders (Dumit 2004, 167). Nevertheless, in popular arenas, the persuasive force of these images invokes as sort of "clear-cut graphical difference" that is subsequently translated into "a clear-cut statistical difference" (Dumit 2004, 17). These differences are visually confirmed, graphically positioned within the internal geographies within which they reside. This is why Pitres' photos seem opaque and void of scientific content. As mental disorder is increasingly conceptualized as something embedded in the physiological processes of the material body, only glimpses into its interior possess the veridical authority to confirm the presence and reality of mental disorder. We have seen (or been shown) the diseased brain.

It is precisely this notion of the diseased brain that negatively contributes to perceptions of persons with mental disorders as physically different. In their landmark study, Sheila Mehta and Amerigo Farina found that while the disease view of mental disorder does improve attitudes regarding attributions of responsibility, it also contributes to harsher sorts of treatment towards persons with mental disorder (1997). In their study, 55 male students were individually paired with a research assistant posing as another study participant. The 55 students were told that the purpose of the study was to investigate how information about working partners influences work performance and outcomes. Each participant was asked to prepare a small written personal statement, including something about his past, current interests, future plans, including something out of the ordinary about themselves. Research assistants substituted a prepared statement prior to the exchange. Assistants were blind to which of the three statements (normal, psychosocial, or disease) they had traded. “Normal” statements included information about one’s enjoyment of college life and time spent with friends, a 3.0 GPA, positive relations with one’s family and siblings, and plans to attend graduate school. “Psychosocial” statements reported adjustment problems beginning in high school, a 3.0 GPA, a couple of psychiatric hospitalizations explained in terms of one’s life experience and upbringing, a treatment plan of talk therapy, and plans to attend graduate school. “Disease” statements reported adjustment problems beginning in high school, a 3.0 GPA, a couple of psychiatric hospitalizations explained in terms of one’s biochemistry or metabolism, a treatment plan of talk therapy and psychopharmaceuticals, and plans to attend graduate school. Pairs were then asked to complete a learning task. This task involved teaching one’s partner a random pattern of button pressing. Separated in different rooms, one’s only means of communicating to his partner was through shocking the learner. Duration and strength of the shocks were left to the discretion of the “teacher,” always a naïve participant.

A self-assessment tool was used to measure participants’ attitudes towards their partners, and behavioural measurements were made of treatment of partners, in terms of intensity and duration of shocks delivered. Outcomes showed that regardless of whether the disorder was characterized as psychosocial or a disease, general negative evaluations still occur. Individuals were characterized as tense, anxious, easily angered, and/or socially awkward. One improvement noticed with the disease model is that individuals were blamed less for their circumstances when their disorders were framed in biological terms. With regards to behavioural measures, the harshness of shocks increased for all three groups by the end of the trial. The increase was sharpest, however, when disorders were described in biomedical terms (Mehta and Farina 1997, 414):

> People evidently do feel they must be kind to those whose illnesses are conspicuous. Yet, the results of the current study suggest that we may actually treat people *more* harshly when their problem is described in disease terms! The contradiction between what we say we do and what we actually do is evident with the disease group but not with the normal nor the psychosocial groups. (Mehta and Farina 1997, 415 emphasis in original)

Mehta and Farina offer three possible reasons to account for the affliction of harsher treatment in response to the disease view of mental disorder. First, positioning persons within the sick role leads to patronizing attitudes. They are like children who need firm guidance and discipline. Second, the disease model potentially contributes to perceptions of persons with mental illness as "physically distinct" (Mehta and Farina 1997, 416). "Biochemical aberrations make them almost a different species. This perception may engender callousness …and conceivably may translate into harsher treatment" (Mehta and Farina 1997, 416).[22] Finally, the disease model invokes the perception that mental illness is a random occurrence and thus provokes people's fears that they too might fall prey. "In turn, the afflicted may become a target for negative feelings insofar as they serve as reminders of this vulnerability. And these feelings of being threatened may give way to harsher treatment" (Mehta and Farina 1997, 416).

Thus while the colourful images of brain sections work to make the diseased brain more legible, and add a sense of legitimacy and objectivity to biomedical models of mental illnesses, they potentially contribute to the impression that this sort of brain is of a particular and abnormal kind. These categorical slippages suggest that so too is the person in possession of the diseased brain of a particular and abnormal kind – potentially the kind deserving of harsher treatment. We cannot escape the shadows of the not-so-distant past when arguments premised upon genetic and biological variation served as justification for eugenics and mental health hygiene movements resulting in the sterilization, loss of freedom, and even loss of life for those marked biologically defective (see, for example, Kevles 1985; McWhorter 2009). The potentially dangerous implications of the biomedical model warn against complacency, and warrant a certain degree of scepticism with respect to its value as an anti-stigma tactic.

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[22] This perception is potentially further exacerbated by the more reductionistic approaches in genetic-environment research. Placing an excessive amount of emphasis on locating the physiological or genetic differences in people who are not as resilient to difficult life circumstances or stressors, from the outset, is premised on the notion that there is something fundamentally different about persons with mental disorders, and thus in many respects are approached scientifically as deficient and physically distinct.

The second drawback of the biomedical model is that conceptualizing mental disorders as dysfunctioning biological processes and therefore beyond the individual's control potentially cuts both ways in terms of stigma reduction. As suggested, this tactic is meant to target assumptions that persons with mental illness are simply weak willed or bad characters. However, claiming that persons with mental illness are not responsible for their conditions can also embolden and underwrite assumptions that persons with mental disorder are untrustworthy and dangerous. Despite the fact that the majority, indeed 80 to 90 percent, of persons with mental illnesses are not violent, the general population fears such labelled persons (Wahl 1999, 19). Certainly a great deal of this fear stems from popular images of mental illness. Upwards of 70 percent of representations of persons with mental illness in prime-time dramas are violent and threatening (Wahl 1999, 19). Yet it is not only these exaggerated and distorted images that possibly add to the perceived dangerousness of persons with mental illness. Biomedical models themselves also potentially contribute to these perceptions:

> When the type of differences promulgated imply faulty brain functioning so severe that a person is denied responsibility for their actions, then our fear may be compounded by the notion that this person could lose control at any moment and by the belief that this unpredictability, which may express itself in a violent manner, needs to be severely, even harshly, controlled. This hypothesis draws support from the finding that the less we hold 'mental patients' responsible for their failings the more harshly we treat

> them, and the less aware we are of the harshness of that treatment. (Read and Harre 2001, 232)

The suggestion that persons with mental disorders cannot be held responsible for their illness or symptomatic behaviours may lead to a generalized fear that they are inherently unpredictable. In turn, this unpredictability might create the illusion that they are more dangerous than the general population and deserving of harsher treatment (see, for example, Read and Harre 2001; Read and Law 1999; Mehta and Farina 1997).

Third, while biomedical models work to enhance access to mental health services, and support claims for more extensive insurance coverage, the range of services available are limited and themselves have been shown to introduce their own distinct forms of stigma. This is not to suggest that psychiatric care is actually worse than what it once was. However, despite advances, the implications of entering into a system of care founded upon a biomedical framework are far from innocuous given the iatrogenic forms of stigma that await service users (Sartorius 2002, 1470-71). At issue is not only how self-concepts are altered in response to a psychiatric diagnosis, but also, post-diagnosis, how persons with psychiatric labels and histories are then treated within the system.

Thomas Scheff first applied labelling theory to mental illness in 1966. His work was influential for introducing a different understanding of mental disorder. In contrast to prevailing views at the time, Scheff suggested that many of the behaviours grouped together under different diagnostic categories of mental illness are in fact products of the labels themselves. Simply put, the logic of labelling theory is as follows: Persons behaving in socially deviant ways are often labelled mentally ill. Once labelled in this way, others come to anticipate and expect certain sets of behaviours from such persons, thereby inhibiting individuals from returning to socially normative behaviours and roles (Scheff 1966, 87). In response, persons so labelled modify their behaviours in accordance with these expectations. In so doing, further deviant, stigmatized behaviours are enacted.

Bruce Link, Jerrold Mirotznik, and Francis Cullen are recognized in the stigma literature for introducing a modified form of labelling theory, which suggests that labelling does not necessarily play a direct or causal role in the production of deviant behaviour. It does, however, often deeply impact the self-concept of those bearing the weight of such labels. Link, Mirotznik, and Cullen argue that the labelling process causes many individuals to internalize previously held negative associations of persons with mental disorder (1991, 303). In turn, self-devaluation occurs, the possible consequences of which often include decreased likelihood of securing employment or well paying jobs, a more limited social network, and lowered self-esteem. Thus, "it is possible that labelling and stigma influence the 'career' of mental patients by inducing a state of social psychological vulnerability to prolonged and recurrent problems" (Link, Mirotznik, and Cullen 1991, 302). In essence, it may serve to exacerbate the condition and the stigma associated with it, causing a rebound or reversal of its intention.

Psychiatric labels not only influence how individuals understand and feel about themselves, but also influence their experiences within the healthcare setting itself. A prime example of the sort of stigmatizing attitudes that mental health service users encounter in the clinical setting can be found in the recurrent dismissal of their other health-related concerns, even those generally considered more physical in nature. In other words, one's diagnostic label often overrides proper consideration of attention to even those symptoms of illness that are distinct from their psychiatric histories. For example, speaking to the tainting effects her psychiatric history has had on her interactions with healthcare providers, one woman states:

> I went to my GP with a breast lump… [he] sent a referral letter stating 'over-anxious patient, had nervous breakdown at age 17' (20 years ago). Consequently I was greeted by the specialist with 'well, you're a bit of a worrier, aren't you?' Every physical illness I have had for the last 20 years has first been dismissed as anxiety, depression or stress. (woman aged 38 cited in Read and Baker 1996, 19)

For this reason, many choose to conceal their psychiatric histories when presenting with concerns regarding their physical health in hopes of maintaining some sort of authority to speak on their own behalf. As Otto Wahl has argued, "Physicians doubt the honesty and accuracy of consumers' symptom reports; thus, the only way to have symptoms accepted as honest and accurate reports is to be dishonest about psychiatric history" (Wahl 1999, 72). Ironically, one had best lie in order to avoid being perceived as a liar!

Women's epistemic status is still tainted by the residual effects of historical accounts of "the female kind" as essentially irrational and overly sentimental, wherein "reason has been defined in opposition to feminine embodiment" (Alcoff 2000, 40). Psychiatric diagnosis further threatens women's consideration as trustworthy and reliable informants. Consider again the influence of abuse and violence in the lives of women with serious mental illness. Despite the fact that this correlation is well documented, a woman's reports of abuse are often viewed "through the coloured lens of her diagnosis. The stigma of her diagnosis is often sufficient to call her account into question" (Harris 1997 cited in Morrow 2002, 7). That is, her psychiatric history often raises suspicions regarding her trustworthiness from the outset. For example, when a woman's testimonies of abuse are seen as suspect, appropriate care is often not secured, thereby exposing her to further harm. As such, women with serious mental disorders are routinely denied the sorts of advantages that accrue to those persons socially recognized as truth-tellers. In effect, then, stigmatization undercuts the capacity of persons with mental disorder to have their voices heard and their concerns taken seriously both within and beyond the healthcare setting.

In sum, the biomedical model of mental disorder, as an anti-stigma tactic, while enabling some benefits for those speaking in its terms, also bears its own set of detriments. The most commonly discussed dangers associated with the model include the promotion of beliefs that persons with mental disorder are of a different kind, untrustworthy and dangerous, and the introduction of new iatrogenic forms of stigma through the processes of diagnostic labelling and psychiatric treatment.

There is one final point that is often overlooked in critiques of the deployment of the biomedical model as an anti-stigma tactic. This point concerns the limitations of the analogies being drawn between mental and physical illness, and the implicit romanticization of physical illness that seemingly underwrites these tactics. I suggest that too much political purchase has been put into the claim or assumption that the body is somehow morally neutral. Even if an illness is the result of a physical lesion or malfunctioning of a biological process, this does not entail that all attributions of responsibility for its occurrence are thereby diminished. This point should be clear now more so than ever given the "culture of wellness" pervasive in the west. Individuals are routinely encouraged to watch what they eat, exercise regularly, reduce stress, and the list goes on and on. Public health agendas increasingly place more and more emphasis on the individual's role in disease prevention. In other words, we must all assume responsibility for our own health outcomes. Heart disease, cancer, and diabetes are all linked in different ways to individual behaviours that potentially contribute to or reduce their rates of incidence. And if we don't connect individual behaviours to disease occurrence through more tangible actions such as diet, smoking, and exercise, there are a plethora of alternative explanations that, for example, correlate disease to repressed and unresolved emotions (see, for example, Mate 2003). Thus mental health advocacy groups premising their anti-stigma campaigns on likening mental illnesses to physical illnesses overestimate the extent to which physical illnesses are understood as something for which individuals are not responsible.

Even more importantly, these campaigns underestimate the amount of stigma that does indeed attach to physical illness. Within the anti-stigma literature there appears to be an implicit romanticization of physical illness as existing free from all stigma. This manifests itself in a sort of false idealization of how physical illnesses are in fact responded to. Consider for example the following quote from a woman named Debbie:

> I'm not ashamed of it [depression], I mean it was . . . something that's natural, it was a natural occurrence. . . .People aren't ashamed to walk around with diabetes or a heart attack. . . .People get cancer, it's not something you're going to hide. It's the same thing. (Debbie, respondent in Stoppard and Gammell 2003, 51)

Although Debbie seems quite certain that no one is going to hide the fact that they have cancer, people do in fact go to great lengths to conceal their illnesses from family members. Whether "natural" or not, cancer bears all sorts of cultural connotations and individuals diagnosed with it clearly come to occupy pathologized and stigmatized locations within the social geography (see, for example, Sontag 2001). Certainly, the degree and kind of stigma that adheres to physical illnesses differs from that which adheres to mental illnesses, just as there is variance in the degree and kind of stigma that attaches to different diagnostic categories within these individual groupings. However, to suggest that likening mental illness to physical illness will at long last dissipate the stigma of mental illness is to oversimplify, misrepresent, and underestimate the personal and social costs of traversing the borders into realm of physical illness (see, for example, Frank 1995).

Biomedical Model of Mental Disorder qua Hub of Economic Activity

As suggested in the last chapter, the financial stakes involved in the acceptance of the biomedical model of mental disorder are vast. This is the case for individual practitioners, mental health advocacy groups, and pharmaceutical drug companies. The influence of Big Pharma in the field of mental health is by now well documented, and familiar to most (see, for example, Horwitz 2002). As such, I will forgo any in-depth analysis of its power. Rather, I will focus more specifically on how the pharmaceutical industrial complex works to manufacture consensus around appropriate treatment protocols, and, how this move plays out in terms of the industry's relations with mental health advocacy groups. The profits of pharmaceutical companies often come at the expense of the professional autonomy of individual practitioners, and availability to the public of unbiased information regarding the effects of drug treatment.

For healthcare providers and federally funded healthcare systems, pharmaceutical approaches are time, and ostensibly cost saving measures when compared to other psychotherapeutic modalities (Luhrmann 2000, 239-65). Some practitioners continue to hold out in psychological courses of care, remaining firm in their commitments to the therapeutic benefits of psychosocial modalities.

Others, however, feeling the financial constraints of doing so, have opted to alter their practices in order to accommodate fee and insurance cutbacks.

Changes in insurance coverage protocols in the United States, for example, have radically altered psychiatric care within both larger healthcare institutions and smaller private practices. Due to changes in how much insurers will now pay practitioners, "To maintain their incomes, physicians often respond to fee cuts by increasing the volume of services they provide…" (Harris 2011, n.p.). These changes have narrowed the range of treatment options that individuals can choose from and receive, as well as imposing constraints on the professional autonomy of individual practitioners.

A recent *New York Times* article directly addresses the shifts in psychiatric care precipitated by changes to insurance coverage and reimbursement rates (Harris 2011, n.p.). The article features an interview with Dr. Donald Levin, one of many psychiatrists in the United States who has stopped offering traditional talk therapy. His practice, in which he at one time met with 50 to 60 patients once or twice weekly for talk therapy, has gradually transitioned to one in which he has a patient load of 1200. In contrast to the extended appointments of the past, current appointments are limited to 15 minutes during which time medications are adjusted and prescriptions are filled – one appointment often occurring months after the previous one. He says:

> At first, all of us held steadfast, saying we spent years learning the craft of psychotherapy and weren't relinquishing it because of parsimonious policies by managed care. But one by one, we

> accepted that that craft was no longer economically viable. Most of us had kids in college. And to have your income reduced that dramatically was a shock to all of us. It took me at least five years to emotionally accept that I was never going back to doing what I did before and what I loved. (Dr. Levin quoted in Harris 2011, n.p.)

Statistics suggest that as of 2005 a mere 11 percent of psychiatrists in the United States still offered talk therapy sessions for their clients. Those who do provide such services tend to cater to the wealthy elite, like those psychiatrists practicing in New York City, where "a select group of psychiatrists charge $600 or more per hour to treat investment bankers, and top child psychiatrists charge $2,000 and more for initial evaluations" (Harris 2011, n.p.). To be certain some psychiatrists continue to provide talk therapy to their patients in the $200 per hour range, and of course one-on-one talk therapy (which can be delivered by psychologists, social workers etc.) is only one of many psychosocial treatment options.

Practitioners working in state funded healthcare systems are similarly constrained in the sorts of care they are able to deliver. As argued by Ian Hacking, "it is a luxury for most clinicians in public service, for they do not have the time for intense psychological care of many clients" (1990, 118). It quickly becomes clear that practitioners are not necessarily voluntarily (in the broader sense of the term) shifting their practices in a pharmaceutical-based direction. Rather the economic benefits of doing so often come at the expense of their professional autonomy.

These constraints are also passed onto those persons seeking mental health care. As the earning potential of many persons with serious mental disorders is often compromised, the ability to pay for such services out of pocket is often limited. Thus despite the general consensus that a mixture of treatment modalities offers the best support for persons with mental disorder, psychosocial treatment is being marginalized as a therapeutic option due to fiscal considerations.

Economic interests are not only driving courses of care, but also the very information that individuals often encounter as they attempt to educate themselves about mental disorder, whether as someone experiencing psychological difficulties or as someone close to another who is. Of particular interest is the alliance between pharmaceutical companies and mental health advocacy groups. For example, NAMI considers itself the United States' national voice on mental illness, and one of its main goals is education and mental health awareness. The broad influence of this organization positions them as gatekeepers or intermediaries between drug manufacturers and end users (Applbaum 2009, 187). In other words, they possess the necessary power and social standing to facilitate alignment between the goals of pharmaceutical developers and mental health service users. Clearly the magnitude of the industry's sponsorship of the Alliance's programs cannot be disentangled from the content of these programs. NAMI has been made the target of fierce criticism for its involvement with the pharmaceutical industry, and so too have the endorsing companies been faced with public outrage.

In fact, “Several workers unions are suing Lilly for its funding of the patient advocacy group NAMI to lobby state and federal governments to increase spending on Zyprexa,” an atypical antipsychotic approved for the treatment of schizophrenia (Applbaum 2009, 197). The 2006 class action complaint brought against Lilly by Local 28 Sheet Metal Workers states:

> Lilly’s funding and partnering with the National Alliance for the Mentally Ill (NAMI) in the late 1990s and early 2000s was designed to accomplish through a non-profit organization what it could not on its own: giving the appearance of independent analysis and a grassroots movement encouraging the use of atypical antipsychotics by state and private insurers. The scheme worked and Lilly certainly benefited from its significant donations to NAMI. Zyprexa was the leading antipsychotic in the world in 2000, capturing nearly 40% of the global antipsychotic market. A year later, Zyprexa was the sixth highest selling pharmaceutical product in the world, with $3.2 billion in sales. (Local 28 Sheet Metal Workers, 73)

The document goes on to suggest that between 1996 and 1999 Lilly donated approximately $2.87 million dollars to NAMI. Lilly also funded a number of NAMI-based programs and educational pamphlets:

> One such Lilly-funded brochure – “Understanding Schizophrenia” – produced by NAMI for patients and families of schizophrenics minimizes the side effects of atypical antipsychotics such as

> Zyprexa. Another – the 2001 “Access to Effective Medications” brochure produced by NAMI National for legislators and paid for by Lilly – lays out a blueprint for nationwide NAMI lobbying of state governments to reduce or remove any limitations to payments for atypical antipsychotics, again down-playing the side effects of such drugs. (Local 28 Sheet Metal Workers, 74)

Further to this, the case reveals that:

> The U.S. Department of Health and Human Services Office of the Inspector General issued a report in 2002 warning that the cozy relationships between non-profit advocacy groups and pharmaceutical companies – such as the one between NAMI and Lilly – which result in the generation of revenue for the pharmaceutical companies could be considered illegal under the federal anti-kick-back statute. (Local 28 Sheet Metal Workers, 75)

Thus in many respects these donations can be more critically understood as financial investments, and bordering on illegal ones at that. The symbiotic relationships between drug manufacturers and non-profit advocacy groups results in a situation in which the educational information distributed to the public is often biased towards promoting the revenues of pharmaceutical companies. Clinical trials revealed that Zyprexa was rated no better in terms of safety or efficacy when compared to older “typicals,” and was nevertheless added to hospital formularies, despite Zyprexa costing a staggering 80% more than haloperidol (Healy 2006, 136). In fact, Zyprexa has been shown to have the highest suicide rates amongst the novel anti-psychotics, and “possibly the highest suicide rates in clinical trial history” (Healy 2006, 140). Despite this, when by 2004, over 200 articles had been published detailing the results of five clinical trials with 2,500 patients, none of these made reference to the high rates of suicide and suicidal acts (Healy 2006, 141). Not only is some of the information being presented to the public biased, but it is also potentially dangerous, even deadly. Thus while the contribution of these companies to mental health advocacy groups and anti-stigma campaigns is beneficial on many levels, it is nevertheless an interested one that cannot be disentangled from the force and power of pharmacoeconomics.

Conclusion

Within this complex set of factors, scientific, professional, cultural, and economic, the ideologies and interests at play work to create a series of detriments for those who speak and are spoken about within these biomedical terms of reference. These constraints include a reductionist approach to mental disorder that overshadows political vectors, the co-opting of anti-stigma campaigns for professional interests, the introduction of a set of stigmatizing misperceptions of persons with mental disorders, the romanticization of physical illness, and the dominance of the pharmaceutical industry and the power it wields. The detriments of the biomedical model of mental disorder thus make it a politically dangerous tool to add to the anti-stigma armamentarium.

Chapter Five

“Breaking the Silence” – The Politics of Coming Out

> While coming out is extremely important for many of us queer folk, unless it amounts to more than just self-naming according to the existing categories, it does nothing but play into existing networks of sexual power. …In that case, labeling myself is just making myself available as an anchor point and target for power – and very possibly for some of the most brutal expressions of power our species has invented. …But even if I don’t end up unemployed and homeless or the victim of violence, even if the people around me are good liberals who would never treat me as if I were queer, my coming out doesn’t alter regimes of sexual power. Self-identification is still sexual identification. Significant though it may be, coming out is not counterattack, and refusing to face that fact will prevent us from dismantling the networks of sexual power that oppress us. We have to attack sexual normalization itself. (BP, 214-15).

In the last two chapters, I discussed the benefits and detriments of the biomedical model of mental disorder as a site of scientific inquiry, a source of professional authority, a locus of cultural identity, and a hub of economic activity. In this chapter, I shift the focus from the institutional level to examine the influences of the biomedical model at the individual level. I examine how biological psychiatry as a style of thought structures the contours of the coming out narratives of persons with mental disorders. In particular, I interrogate them as a form of confessional practice, which “has become a means of identifying individuals and establishing and enforcing their locations within power/knowledge networks” (McWhorter 2001, 116). While promises of freedom are extended in exchange for coming out of the shadows with one’s mental disorder, I argue that these narratives qua confessions are reductive and have mixed political effects.

My reading of these narratives is wedded to an alternative conceptualization of the category of experience, wherein experience is neither transhistorical nor foundational to knowledge. Thus I begin the chapter with a brief review of contemporary feminist and Foucauldian concepts of experience in order to provide a theoretical context for the textual analysis that follows. I highlight what is at stake in our concepts of experience, and why it is an important category of consideration and analysis in its own right, rather than a taken-for-granted backdrop against which interpretation plays out. I then proceed with looking at "coming out" and its relation to identity with a close reading of Ladelle McWhorter's carefully developed critique of sexual identity politics, which revolves around her own coming out (and her resistance to the very idea of coming out). The overall analytical framework of the chapter assumes a similar form to that of chapter two, wherein I took Foucault on sexuality and applied his account to mental disorder. Here I take McWhorter's work on sexual identity politics and coming out and apply it to mental disorder. As Lynne Huffer argues, being queer has long been conceptualized *as* mental disorder (2010). Thus this leap is perhaps no leap at all, especially as McWhorter writes about being institutionalised at one point in her life for being queer. As such, the constraints of coming out, and the constraints of biomedicalized narratives of mental disorder are obviously interrelated, and perhaps even synergistic in the sense that the two genres have similar sorts of constraints and similar sorts of political effects. This analysis thus serves as a theoretical guide for looking at confessional narratives – the genre that I argue dominates psychiatric autopathography.

McWhorter's anti-coming out story provides a philosophical framework for my reading of Elizabeth Wurtzel's *Prozac Nation* (2000 [1994]). While this memoir has perhaps been overworked (see, for example, Fee 2000; Muzak 2008), I take it to be an exemplary model of confessional narratives informed by the biomedical model of mental disorder. As both Foucault and McWhorter make clear, confessions are both enabling and constraining. Therefore, I begin this section with an examination of the speaker's benefits associated with this form of autobiographical narrative, in particular its deployment as a means of self-production and sense-making. I then proceed to query the constraints presented by such narratives as reflected in McWhorter's own anti-coming out story. Within the context of this reading, I make explicit my concerns with the sort of narrative scripts the biomedical model imposes, and, more importantly, the implications this has for how individuals come to understand, interpret, and experience themselves, and how this experience is subsequently deployed in the production of knowledge.

One's coming out is often solicited, performed, and experienced as an act or expression of personal freedom, authenticity, and liberation. Yet confessions are offered up in socially sanctioned venues, within the confines of particular modes and terms of expression. In the contemporary context, the psycho-narrative is constrained by a biomedical discourse that assembles it in individualizing, pathologizing, and reductive terms. Thus coming out is much more, and, at the same time, much less than a breaking of the repressive shackles of silence. Transgressing the boundaries of silence is not simply a matter of speaking one's truth; it is the speaking of one's truth within a normalized paradigm specific to accepted confessional rituals of the day. Uncritical adherence to these scripts and rituals forecloses the possibility of critically engaging the conditions that make certain categories of experience epistemologically salient.

Experience, Knowledge, and the Self

The articulation and sharing of personal experiences have played central roles in a number of different political liberation movements. Feminism has long been concerned with offering multiple, alternative, and subaltern stories. Such narratives, for example, were central in the consciousness-raising groups of the second wave women's movement. The force of these narratives stemmed from their ability, collectively taken, to reveal shared experiences of oppression and marginalization providing resources for self-reflection and individual and collective empowerment. This in turn brought into relief alternative readings of history and more nuanced understandings of social dynamics and power relations occluded by dominant readings of these structures and the persons they disenfranchised. Because of these powerful effects, recourse to personal experience has formed an integral part of women's history, gender studies, and feminist theory as a whole.

This collectivization of experience, however, also brought with it a series of damaging effects given its propensity to crystallize certain identities, overshadowing differences among group members. Within feminist theory this precipitated a debate within which the category of experience itself became the object of interrogation. This debate is important for the analysis of personal narratives that follows because divergent understandings of what experience is and what it reveals determine the political effects and reception of the texts I engage. Thus I am interested in taking this debate that has been sophisticatedly analysed within feminist theory and introducing it to the field of philosophical psychopathology, where personal narratives have yet to be engaged in light of this conceptual analysis of the category of experience.

In her germinal article, "The Evidence of Experience," Joan Scott (1991) offers a post-structuralist reading of, and response to, the ways in which experience has been used to reinterpret history from subaltern perspectives.[23] Scott's primary concern resides with the form of epistemological foundationalism that is often adopted here, wherein experience is taken to be an unmediated source of knowledge, and an unquestioned given. Personal experience, from this perspective, can be used to reveal truths about certain social locations. While these revelations can work to challenge normative history, Scott contends that this approach risks foreclosing further critical inquiry into the conditions of possibility of these experiences and the subjectivities they inscribed.

In examining categories of difference, individual testimony can function to expose histories of domination and exclusion. However, if there is no interrogation of how individuals initially come to be marked as different in the first place, these testimonies can work to naturalize the very differences they

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[23] A later but substantially similar version of this article, entitled "Experience" appeared in Judith Butler and Joan W. Scott (1992). This later version was very influential, widely read, taught, and cited. As Linda Alcoff suggests, then, Scott's work is "a central place from which to observe the current features of post-structuralist feminist theory" (Alcoff 2000, 44).

represent. In the absence of a genealogical account of difference, "The evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world" (Scott 1991, 777). When we talk about sexuality, mental disorder, social class, or whatever other categories of difference we might wish to explore, and we deploy experience as the primary means through which we come to knowledge, we can easily overlook the constructed nature of experience itself. In turn, we mistakenly assume that the facts of sexuality, mental disorder, social class, of difference have been established (Scott 1991, 777). When these categories are taken as naturally occurring entities, a homogenizing effect occurs. "The unifying aspect of experience excludes whole realms of human activity by simply not counting them as experience, at least not with any consequences for social organization or politics" (Scott 1991, 785).

One of the primary problems associated with this foundationalist approach, Scott argues, is that this approach naturalizes the identities ascribed to individuals occupying these locations, often foreclosing an analysis of why these locations and identities gained their epistemological salience to begin with. Feminists might often point to an individual experience of male violence, for example, and surely this was always with the goal of identifying patterns of experience that would then be subject to political analysis. However, in taking these experiences as their epistemological starting point, and making secondary the querying of the conditions of possibility of these experiences, they risked overlooking the ways in which this experience is historically and discursively constructed. Thus while recourse to personal experience can challenge normative history in some respects, "by remaining within the epistemological frame of orthodox history, these studies lose the possibility of examining those assumptions and practices that excluded considerations of difference in the first place" (Scott 1991, 777). In other words, reference to experience, in the absence of counters to the ideological systems that make them possible, simply reinforces these sorts of events -- in effect, reproducing the ideological systems from which they arise.

To escape these marginalizing and homogenizing effects, Scott suggests that experience and the identities it constructs need to be actively historicized. In other words, if we want to actually transform experience, rather than simply make it visible, we need to examine the socio-historical conditions that make certain kinds of experiences possible, and the surrounding discourses that mark them as significant. It is only through reference to culturally available scripts that we are able to describe and make sense of these experiences. We do not experience different events in an unmediated way, nor are we capable of describing them without recourse to the scripts that make them intelligible in the first place. History founded on personal experiences is important for its ability to reveal cycles of oppression and domination, but it risks doing so at the expense of critically engaging the ideological systems that contribute to these forms of exploitation, and the subjectivities they inscribe and fix (Scott 1991, 778). Scott thus recognizes the important political impetus behind the use of personal experience, and does not advocate that its use be discontinued. As she suggests, however, recourse to personal experience is, at once, both enabling and constraining (Scott 1991, 776). "Experience is at once always already an interpretation *and* something that needs to be interpreted. What counts as experience is neither self-evident nor straight-forward; it is always contested, and always therefore political" (Scott 1991, 797).

In response to Scott, Linda Alcoff, a phenomenologist, argues that experience has a primacy that cannot be captured by discursive explanation alone. She suggests that Scott weds experience too closely to language, and in doing so, overlooks the fact that some embodied experiences exceed their discursive descriptors. These experiences are still set against and occur within a particular cultural horizon. Nevertheless, Alcoff argues that the poststructuralist position has a propensity to reduce embodied experience to discursive explanations, construing traumatizing experiences as indexed exclusively to social context. Alcoff wants to incorporate a "critique of the ideological content of corporeal experience within an overall theory that bases knowledge on experience" (2000, 39). In other words, like Scott, Alcoff is concerned with how women's experiences can be represented without reproducing the ideological systems that inform them.

Thus both Scott and Alcoff are trying to hold onto the strong feminist legacy of valuing women's experiences. Each recognize the epistemic importance of marginalized experiences, and that these experiences occur on a cultural horizon. Nevertheless, Alcoff argues that Scott has swung the pendulum too far in her renunciation of the evidentiary value of experience, and the political potential of phenomenological descriptions *as* phenomenological descriptions, and not merely as illustrative adjuncts in discursive descriptions. In binding experience so tightly to discourse, Alcoff suggests that the poststructuralist position risks negating the possibility of certain experiences happening before the language exists to describe them. As she states, “Experience sometimes exceeds language; it is at times inarticulate” (Alcoff 2000, 47). A more nuanced understanding of experience must give due to the gaps and interstices occurring where language and embodied events do not seamlessly align themselves.

Both Scott and Alcoff engage Foucault’s work in making their analyses—the former in a sympathetic reference to Foucault as the defender of the view that all experience is discursively produced, and the latter in a critical article that challenges Foucault’s alleged inattention to traumatic experience. Alcoff turns to the case of sexual violence to demonstrate that not all experiences can be fully articulated linguistically. She argues that because certain embodied elements will almost always exceed their discursive interpretations, in order to effectively theorize sexual violence, personal accounts of the actual embodied experience of it must necessarily be taken into account (Alcoff 2000, 52). In the absence of such descriptions, we are at greater risk of inferring that “rape itself might be the product of an interpretation, either a misdiagnosis of an event or an experience whose traumatizing effect might be the product of a particular politics” (Alcoff 2000, 52). As a case in point, Alcoff takes to task Foucault’s description of the case of Jouy, the simple-minded farmhand, and the little girl from whom he received “a few caresses” (see HS1, 31-32; also detailed in chapter two). She argues that in his telling of the incident, Foucault fails to offer any meaningful account of the girl's experience of the interaction. Rather his emphasis remains on how the discursive interventions surrounding this occurrence were what precipitated different meanings and content to the experience. Alcoff argues that this approach necessarily overshadows other important features, namely the embodied experience of the little girl.

It is precisely these sorts of embodied accounts of one's experiences that Alcoff suggests are capable of fuelling powerful political transformation. She argues that the tactic of breaking the silence on suppressed experiences, as illustrated by the rape survivors' movement, demonstrate that "such subjective descriptions have often had subversive political effects, when they challenge existing epistemic hierarchies concerning what kinds of embodied speakers have credibility and authority, and when they raise questions about the benign status of institutionalized heterosexuality" (Alcoff 2000, 46). Given these productive effects, Alcoff argues phenomenological accounts ought not to be reduced solely to illustrative data, but rather are to be incorporated directly into the formation of knowledge itself (2000, 56).

Silvia Stoller echoes these sentiments when she suggests that phenomenology can fill in the gaps created at the limits of poststructuralism. Taking the example of fear, Stoller argues that while the poststructuralist can provide an account of the discourses informing experiences of fear, they cannot describe the actual affective experience of the emotional state itself:

> In this context, it is irrelevant whether or not the fear is justified or based on an illusion or produced by discourses: the causes of fear

> are not at issue here. A phenomenological examination of fear is, instead, interested in analysing experience as a phenomenon; or, in the case of fear, in describing how fear manifests itself to the subject experiencing it. (2009, 721-2)

Discursive explanations can only ever offer a partial glimpse into an experience, and therefore, in the absence of recourse to embodied accounts, such descriptions remain incomplete (Alcoff 2000, 55). Experience possesses its own cognitive value, independent of its discursive interpretations. In and of itself, "experience produces knowledge" (Alcoff 2000, 51).

While Foucault does negate the experience of the little girl, as Alcoff suggests he does, this does not mean that he does not incorporate or leave space for subjective experience as a whole. In this particular case, experience does play a central role. However, it is the experience of the farmhand that Foucault makes the object of his analysis. Certainly this exclusion of the little girl's experience betrays a degree of masculinist bias, and has rightly been criticized by feminist philosophers. Nevertheless, as Johanna Oksala argues, Foucault's treatment of the case makes it clear that experience plays a central role in the overall project undertaken in *The History of Sexuality.* As she argues, "If Foucault held that subjective experiences were simply coextensive with dominant expert discourses, as Alcoff claims, there would be no need, or possibility, for him to undertake them" (Oksala 2011, 214). The example of Jouy then is meant to illustrate the gaps between his experiences of the incident, and how this situation was interpreted and responded to. It is meant to show that the farmhand's experiences are not reducible to the discourses that surrounded him, but that they nevertheless intervene and bump up against these experiences, transforming how they are lived.

These gaps and the political potentials they possess figure centrally in Foucault's work, and in the theories of many who follow in his footsteps. It is through a juxtaposition of subjective experience with its discursive construction that these fissures reveal themselves. Thus, as Oksala argues, in many respects much of Foucault's work can be read as "historical inquiries into particular modes of experience" – for example, those of the madman, the prisoner, and the homosexual (2011, 209). Foucault therefore does not negate the importance of experience, nor does he posit it as being seamlessly aligned with language (Oksala 2011, 209). Experience is neither wholly objective nor is it wholly subjective. As Oksala suggests:

> …we might think of it [experience] as a series of foldings: the subject must fold back onto itself to create a private interiority while being in constant contact with the constitutive outside. The external determinants or historical background structures of experience and the internal, private sensations fold into and continuously keep modifying each other. (2011, 211)

Experience, on this view, is both constituted and constitutive. "The same process through which such objects as madness or sexuality emerge in history also involves a corresponding process of emergence of a subject capable of knowing and experiencing such objects" (Oksala 2011, 212). Experience is only made intelligible through reference to cultural scripts, and it is through such experiences that different subjectivities and social locations arise. "…While the personal, lived, or subjective experience is not ontologically or epistemically foundational or self-sufficient in Foucault's analyses, it is nevertheless indispensable" (Oksala 2011, 214). It is in the fractures where experience and discourse do not seamlessly align that the potential for transformation resides. "The potential for change emerges out of these fractures, from the space of critical self-reflection created by the self folding back upon itself" (Oksala 2011, 219). These foldings create the kind of subject who can have that paradoxical thought – this critical I that is thinking is also an I with a genealogy. This paradoxical thought is what makes possible the ability to speak about oneself while at the same time speaking about how people speak about themselves.

What would it look like to introduce this feminist debate concerning the category of experience to this relatively new field of philosophical psychopathology? To begin answering this questioning, I turn to McWhorter, who pointedly questions how she can tell her own story in light of what a Foucauldian approach to experience has to say. She reveals how straightforward confessional events that fail to interrogate the discourses circulating around and within personal experience work to naturalize categories of identification, and reduce individual subjects to cases of epistemic inquiry. McWhorter interrogates how reified categories of identification have shaped and informed her identity, speaking of her own experiences while at the same time situating them within the historical and political conditions that made them possible. And in this telling she locates political resources for resistance and counterattack, and personal transformation. I then present a memoir, *Prozac Nation* (Wurtzel 2000, [1994]), where the author has not considered this debate, nor addressed the complexities of the category of experience itself. She expresses her experiences in a way that remains largely uncritical of the ideological systems that inform and categorize them, and as a result, as I will show, the narrative is highly overdetermined, and falls prey to the dangers that McWhorter so deftly cautions against.

Ladelle McWhorter's Anti-Coming Out Story

Ladelle McWhorter's story of her own coming out makes clear the difficulties of negotiating the terrains of shame and concealment. She long struggled with how to, in one and the same move, say some important things about her life, while at the same time wanting to speak in opposition to the deployment of sexuality as a disciplinary measure. In *Bodies and Pleasures* (1999), McWhorter configures these experiences in light of her reading of the preliminary sections of Foucault's *History of Sexuality* (which I detailed in chapter two). In what I refer to as her anti-coming out story, McWhorter resists the dominant discourses and confessional practices surrounding sexuality. In line with Foucault, she pinpoints two primary problems associated with confessional practices. First, the confessional subject is reduced to a "case" or "kind." In other words, the living subject is transmuted into an object of specialized knowledge. Second, McWhorter argues that, contrary to the conceptual wedding of speech with freedom, confessional practices are not liberating in their effects for those marked deviant.

In the earlier stages of her life, McWhorter was aware that she was attracted to girls. What she did not know then was that in the eyes of others this attraction made her a particular "kind" of person. It was not made apparent to her until one day she came across the word "homosexual" in a magazine, and queried her mother as to its meaning. It was made clear to her, more through the tone of her mother's reply than anything else, that a homosexual was a particular kind of person, and an unsavoury kind at that (BP, 1).

Following this brief discussion with her mother, McWhorter continued to gather information about "homosexuals." What she discovered was that identification as a homosexual enlists a series of beliefs about, expectations of, and responses to individuals so labelled (BP, 2). In other words, were she to openly identify herself as queer she would be limiting herself in terms of the recognition she would receive from others.[24] As a particular kind of person, the identification of which forecloses recognition of other important qualities, her movements and choices in the world would be restricted. How these movements and choices would be interpreted, classified, and responded to would also be constrained.

As McWhorter writes, "When somebody finds out you're queer, they forget everything they ever knew about you; or if they remember anything about you at all, the things they remember just get reinterpreted as nothing more than symptoms of your disease" (BP, 2). Identification and classification as a homosexual is thus reductive. The category comes to function as a lens through

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[24] Identification as "queer" specifically now carries a connotation of trying to escape identitarian politics, but McWhorter uses it as the epithet for homosexual it originally was.

which others view the individual. It is no wonder, then, that in contemplating coming out, McWhorter feared she would become "*a reified pervert, thoroughly discredited and unable to speak*" (BP, 110 emphasis in original).

Foucault's *History of Sexuality* had lent McWhorter some personal and philosophical traction in her concerns with the processes of sexual identification and classification. In particular, Foucault confirmed her suspicions regarding the arbitrariness of locating sexuality as the primary identifying feature of individual selves. Foucault's genealogy detailed how the importance placed on sexuality as definitive of one's essential nature is the contingent historical and cultural product of a number of different institutional and disciplinary confluences. Foucault's writings had shown McWhorter that she could "be a homosexual fully and completely" while "[refusing] to be a homosexual essentially" (BP, 30). Armed with a genealogical account of homosexuality, she could now adopt that critical position in which she could speak about her experiences, while at the same time questioning the conditions of possibility of the subject position from which she spoke. McWhorter remains critically aware of the constitutive world with which she is in constant contact while "folding" in on herself to create a private interiority. As she writes, "The reductive categorization could be undermined even while the social position and identity could be acknowledged and affirmed" (BP, 30). Yet despite this theoretical knowledge and sense of freedom in her coming out, McWhorter was nevertheless confronted with the question of how she would enact this identification. What would it look like for her to be openly homosexual in the world? One possibility would be to minimize her homosexuality. In other words, she could distance herself from the tainted status in order to show others, the "normals," that she was not to be feared, that she posed no threat. She is – homosexuals are – just like everyone else. The reifying nature of sexual identification, however, makes it such that one cannot easily, in the same moment and location, straddle two worlds. One cannot be both homosexual *and* like everyone else. As McWhorter states, "Just as they 'forget' anything else they knew about you when they discover you're queer, so they 'forget' you're queer when they have to deal with you as a neighbor or co-worker" (BP, 5). The individual can thus be either homosexual/mad or neighbour/co-worker, but they cannot be both.

Of course, her tolerant friends and acquaintances would be unlikely to hold it against her. They would wilfully forget her queerness. However, as McWhorter states:

> this 'tolerance' in the final analysis amounts basically to the same stance as that taken by reductivist homophobes. To both groups homosexuality is a known quantity, an epistemic object rather than a subject position or social location intimately related to other subject positions or social locations from which self-aware human beings perceive the world and speak. To both groups, to identify with the object 'homosexuality' is to cease to be a human agent. (BP, 30)

It seems therefore that either one is entirely reduced to the object or cannot fully identify as the object. As Foucault suggests, we too often take these categories or objects as stable, eternal, and ahistorical entities. We forget that we have created them, and that they are the product of a set of historical circumstances, and in that forgetting we have allowed them to become solidified. We need the mentally disordered person to be seen as irrational. We need the homosexual to be a pervert. As a result, the mentally ill person or the homosexual (or the homosexual qua mentally ill person) is excluded as a member of that kind when they do not fit the archetype.

Thus, rather than experiencing her coming out as a sort of liberation, an expression of her true self, for McWhorter it was a "[surrendering] to a socially constructed identity that brought with it a set of strict limitations, expectations, and requirements over which I had little control. I chose it because I finally admitted that I had no choice. My resistance had been futile…. I had failed" (BP, 106). She had failed in the sense that for so long her identity was bound to her resistance to a sexual reductionism that would distil the entirety of her selfhood down to her sexual practices. As such, her coming out, while it did bring some relief, was also experienced as a "betrayal" of all she had known and been (BP, 106). One of the primary problems, then, in making one's experiences available for public consumption is that one is reduced to one's deviant status. The effect of continually offering up one's sexuality as an object of knowledge is to undercut the ongoing transformation of personal identity and fluidity of the subject's lived experience.

In this way, confessions are far from liberating, especially considering the very tangible and material effects they can precipitate. McWhorter's experience is indicative of this, for at eighteen years old she was institutionalized for being queer. During her period of hospitalization, it was made painfully evident to her what it meant to speak from a stigmatized and pathologized position. It taught her that speaking was not liberating and was not to be equated with freedom. Despite the exhortations of the 1970s to speak up, that "silence is dangerous" (BP, 12), especially with regards to one's sexuality, McWhorter recognized that this was not the case for deviants. As she states, "If you are powerless enough, even your own words can belong to your enemies" (BP, 8). For those who deviate from the norm, whether sexually or mentally, freedom is not necessarily what follows from confessing one's inner truth.

Diverse and varied arrays of interests are served by the current configuration of sexual identities and injunctions to confess, for they collectively function as an "administrative imperative" (BP, 18). Confession serves as a means of gathering information, establishing the facts about the matter – knowledge that can then be deployed to discipline individuals and populations. It facilitates access into private spaces, creates and naturalizes new categories of perversions and deviants, engenders constant surveillance (both external and internal), and saturates the fabric of our lives. In other words, "knowledge is the first step toward discrimination" (BP, 13). Confessions and the information contained therein become objects of knowledge, and so too do the persons who make them speak.

As McWhorter makes clear, the implications of confessional practices are such that individuals become cases of epistemic inquiry and solidification, and the collection, classification, and coding of these individual cases becomes a means of disciplining populations. In the process, identities (e.g., homosexual, mentally ill) are naturalized. These processes are facilitated through the near ubiquitous supposition, by both authors and readers, speakers and hearers, that confessional narratives, or the revelation of one's personal experience, is taken to be beyond critical analysis or challenge. When experience is taken as foundational to knowledge it is often mistakenly assumed that the facts of the matter have been established. And it is these facts that are then put to the service of disciplinary measures used to govern individuals and populations. Through adopting the genealogical approach that she does, McWhorter is able to speak about her experiences while at the same time interrogating the systems that structure and inform them. In so doing, she reveals the gaps between the governing discourses and her own lived experience, unearthing new possibilities for personal and political transformation.

Elizabeth Wurtzel's Confession: Prozac Nation

> [WURTZEL] …is funny…she is thoughtful…and she is very, very brave. Wurtzel portrays, from the inside out, an emotional life perpetually spent outrunning the relentless pursuit of what she describes as a black wave, often sacrificing her likability on *the altar of her truth* (*Vanity Fair*, cited on back cover of *Prozac Nation* (PN, emphasis added)).

In the 1990s, "The Decade of the Brain," a number of popular psycho-narratives were published making the sort of elisions that McWhorter's interpretation of Foucault warns against. What makes these coming out narratives different from McWhorter's, whose text is obviously quite revealing and relies heavily on personal experience, is that these narratives tend to express their author's experiences in a way that is uncritical of the conditions of possibility of that experience. While there is often resistance to being diagnosed or taking pharmaceutical drugs, there is a glaring lack of reference to the hows and whys of diagnosis and drugs at all. In other words, there is no questioning as to how and why we have come to understand, interpret, experience, and treat problems of living in this way. The interests and power/knowledge structures that are served and reinforced by the dominant style of thought are similarly not interrogated. These narratives are the very sort of reifying confessional events in which authors become read as cases, "a collection of specific deviations from the norm" (BP, xviii), and, as a result, contribute to the completion of the disciplinary trajectories already set in motion--those very trajectories that mark the authors as deviant to begin with. These critical omissions suggest that coming out narratives of this sort do not represent a break with the stigma hypothesis, but rather are complicit with it.

The coming out narratives I am particularly interested in here are those informed by a biomedical perspective on mental disorder. The continuing dominance of this perspective has ushered in a narrative script (Karp 1996, 72). Stories generally traverse a period in which speakers experience distressing feelings, thoughts, and/or behaviours, but continue to link these to external influences and environmental stressors, towards a worsening of their conditions, at which point the author comes to the belief that their distress is internal to themselves. Eventually there is a peak to the distress or an acute crisis, following which medical attention is sought, and diagnoses are often given. The resolution of such narratives generally pivots around the individual's personal reckoning with the new illness identity. The content of these narratives are what make them specifically biomedical rather than the general form itself. What makes this so is that the etiological explanations and diagnoses given are framed within biomedical terms, and courses of frontline care often include prescriptions of pharmacological treatments. Within the terms of this etiological paradigm, one comes to reinterpret one's past experiences, understand one's current situation, and project one's future prospects. To be certain, other psychological theories of mental disorder can and do provide alternative interpretive structures. For example, the psychoanalytic model is even more obviously scripted than the biomedical model. The biomedical model does not entirely supplant reference to these others interpretive models, although it does often come to overshadow other contributing factors. As Nikolas Rose characterizes it:

> To say we have become "neurochemical selves" is not to say that this way of relating to ourselves has now displaced or replaced all others: different practices and locales embody and enjoin different senses of selfhood, and the idea that each culture or historical period is characterized by a single way of understanding and relating to ourselves is clearly mistaken. But I suggest that a neurochemical sense of ourselves is increasingly *being layered onto other older senses of the self, and invoked in particular*

> *settings and encounters with significant consequences.* (2007, 222-23 emphasis added)

Thus, even when other theories structure the telling of one's experiences, these narratives are often punctuated with references to the physiological foundations of mental disorder premised on the assumption that they reveal something fundamental about the nature of mental disorder.

The structure of these narratives is at once both enabling and constraining. It is enabling in the sense that mental disorder qua biological disorder functions as a site of self-production, and can be sense-making for those persons seeking some sort of explanatory hold. However, it is also constraining in its effects. As per Foucault and McWhorter, this sort of narrative script renders the individual a case, placing limitations on the ways in which individuals relate to and express their experiences. It also influences how others understand and respond to such persons. As studies like Mehta and Farina's have made clear, the medical model risks marking others as different kinds (1997). Thus there is a doubling of the effects of this narrative – not only do they reify the category of difference, but they do so in potentially dangerous ways.

I take Elizabeth Wurtzel's *Prozac Nation: Young and Depressed in America* as an exemplary model of the genre of psychonarrative that falls prey to the dangers of confessional practices (2000 [1994]). My goals in providing this reading of her text are twofold. First, I illustrate the influences the biomedical model of mental disorder has on the telling of her story. What is apparent in her text, as in other narratives of this genre, including the plethora of shorter narratives published on mental health advocacy websites, is that the biomedical model and its focus on causation and responsibility, neurotransmitters and chemical imbalances, all play a central, if somewhat ill-defined and inconsistent role. Wurtzel unquestioningly accepts and internalizes this etiological paradigm, coming to understand and relate to herself as a set of deviations from the norm. It is a straightforward confessional event that leaves her exposed to the dangers of uncritical self-identification. This event, then, stands in direct contrast to McWhorter's text, which surely exposes herself, "but in the process it exposes the processes and mechanisms of exposure, those processes and mechanisms in their political investments and, hence, epistemological dubiousness" (McWhorter 2001, 116). My second goal is to illustrate how Wurtzel's understanding and uncritical interpretation of her experience limits the potential for both personal and political transformation and possibility.

In this particular memoir, Wurtzel vividly recounts her experiences with depression over a series of years, describing what it feels like to be depressed, how it undermines her ability to fulfil her obligations with school and work, how it threatens her relationships, and how, at times, it overwhelms her and pushes her to contemplate, and at one point attempt, suicide. A central piece in this narrative is her search for a causal explanation as to why she is this way, why she undergoes such prolonged periods of despair. This is a key feature of many such narratives, wherein, quite understandably, the desire to sort out the causal origins of one's psychic pains or troubled behaviours is a strong one, often occupying much of one's time and energies.

Throughout the text, Wurtzel references a number of different potential causes – her troubled childhood, her father's alcoholism, the history of depression in her family, and even the historical context and setting in which she was raised. Like many who wish for something concrete and tangible to point to, early in the text Wurtzel muses:

> I found myself *wishing* for a real ailment, found myself longing to be a junkie or a coke-head or something – something real. …What does getting depression mean? Learning to keep away from your own mind? Wouldn't it be a whole lot easier to get rid of Jack Daniels than Elizabeth Wurtzel? (PN, 68 emphasis in original)

She is relentless in her pursuit of some meaning, some purpose for her despair. It is following regular meetings with a psychiatrist and a long-term stay in an infirmary that she finally finds the answers she is looking for. It is also at this point in the text that Wurtzel's description of what is going on in her life takes on a distinctly medicalized vernacular.

Wurtzel describes how the physicians arrived at her diagnosis:

> This diagnosis was not easy for them ...as the occasional appearance of manic-like episodes (for instance, during my energetic first month in Dallas) might indicate that I suffer from either manic-depressive illness or cyclothymia, a milder type of mood-swing disease. But in the end, the diagnosticians conclude that I've been too persistently down and not florid enough in my

> manic periods to be bipolar. Atypical depression is long-term and chronic, but the sufferer's mood can occasionally be elevated in response to outside stimulus. (PN, 298)

Here, Wurtzel lists off characteristic symptoms rather axiomatically, as though the possibility of them being contested is not a live one. Psychiatric classification and nosology have given her the "real ailment" she was looking for. Wurtzel references the prescription of fluoxetine (Prozac) she has been given to treat her newly ascribed diagnosis of *atypical depression*. There is something going on in her brain that is not quite right, and part of the solution is pharmacological in nature. In her search for a causal explanation of her despair, she points to a number of historical, familial, environmental, and biological factors, without ever querying the conditions that make depression a salient category of experience, or why it is defined in these terms. Her ultimate adoption of the biomedical explanatory model eventually begins to occlude further consideration of other factors she once thought linked to her depression. Whatever other external factors might have brought her to her current state of mind at least one part of the etiological puzzle is beginning to fall into place:

> Where my depression is concerned, the fact that Prozac in combination with other drugs has been, for the most part, a successful antidote, leads me to be believe that regardless of how I got started on my path of misery, by the time I got treatment the problem was certainly chemical. …Had I been treated by a competent therapist at the onset of my depression, perhaps its mere

> kindling would not have turned into a nightmarish psychic bonfire, and I would not have arrived at the point, a decade later, where I needed medication just to be able to get out of bed in the morning. (PN, 345-46)

Whether attended to at its onset or in the midst of her “nightmarish psychic bonfire,” the implicit message is that depression is an illness for which one must seek professional treatment. I highlight this point not because I am in disagreement with it or because I deny the obvious benefits of receiving therapeutic care for one’s mental distress. Rather I see these statements as salient because they illustrate how particular sorts of narratives conduct one’s conduct through its endorsement of the technical devices and disciplinary measures of biomedical psychiatry. Elsewhere she surmises:

> It is the cognitive dissonance that is deadly. Because atypical depression doesn’t have a peak–or, more accurately, a nadir–like normal depression, because it follows no logical curve but instead accumulates over time, it can drive its victim to dismal despair so suddenly that one might not have bothered to attend to treatment until the patient has already, and seemingly very abruptly, attempted suicide. (PN, 299)

The troubled individual is referred to as “the patient,” despite the fact that it is in reference to an individual who “might not have bothered to attend to treatment” (PN, 299). In other words, even prior to engagement with mental health services, the person, in virtue of the cognitive dissonance he or she is experiencing, is already considered a patient. Thus while Wurtzel's diagnosis confirms the reality of her experience for her, so too does the way she confesses this diagnosis subtly work to confirm the reality of the diagnosis itself. Wurtzel is living proof of it. Her experiences reveal the truth of atypical depression. In her uncritical acceptance of the etiological paradigm of biomedical psychiatry, the categories upon which she makes sense of her personhood and psychic distress are taken for granted as ahistorical givens, existing prior to and outside of relations of power. These categories, as a result, are naturalized, solidified, and depoliticized–atypical depression, Prozac, patient.

Once diagnosed with a form of depression that is long-term and chronic, Wurtzel reinterprets her experiences in relation to this diagnostic category, wherein she comes to understand her depressed state as her own normative baseline. As she states, "This diagnosis [atypical depression] seems a better way to explain the periodic occasions when I *seemed happy or productive*, but would always return to my *normally depressed state* in perfect boomerang fashion" (PN, 298-99 emphasis added). The diagnostic label she has been dealt provides her with a ground note from which to interpret her past, endure her present, and prepare for her future. Atypical depression gives her something to work in relation to.

This sense of relief echoes Stoppard and Gammell's (2003) findings, as discussed in chapter three, that many find solace in finally receiving a medical diagnosis that helps to legitimate and make sense of their experiences. The biomedical model of mental disorder and the causal explanations and treatments it suggests, thus creates new ways of understanding, conceptualizing, making, and governing the self. As Dwight Fee argues, “depression seems to be a site of self-*production* …used to construct meaning and build personal significance” (2000, 85 emphasis in original). However, while psychiatric diagnosis offers Wurtzel some reprieve in her search for an etiological explanation, the way it quickly becomes her dominant interpretive lens is particularly troubling. So complete is her uptake of the diagnosis that she calls into question the authenticity of these periods, where now she only *seemed* happy and productive. Her happiness and productivity are reduced to mere products of her mood being “elevated in response to outside stimulus” (PN, 298). They are related to clinically, in a sterilized and reductionistic vernacular. She is somehow removed from these experiences, turning the gaze upon herself, and in the process objectifies her happiness and productivity in her adoption of a medicalized turn of phrase.

With this new interpretive framework, her “energetic first month in Dallas” is re-interpreted and explained as part of “a manic-like episode.” This period of “boozing around” (PN, 162), in which she “wrote like crazy” and would “just blab and blab” (PN, 155) somehow becomes more intelligible. My point here is not to suggest that Wurtzel is being disingenuous in her claims that her diagnosis explains her experience. Rather what I want to highlight here is how this in turn colours how she understands and interprets her past periods of happiness and productivity. Everything becomes symptomatic of her disease.

Within the context of Wurtzel's reinterpretation of her past behaviours, the entirety of her experiences is crystallized into this one thing: atypical depression. She, in effect, relates to herself as a case, as an object of epistemic knowledge. Important features of herself become subsumed under her psychiatric diagnosis. Whereas McWhorter made clear that her coming out would mean that *others* would forget everything else about her, Wurtzel internalizes the reductionism, and when presented with this new form of self-identification seemingly forgets everything else about *her self*. Atypical depression becomes definitive of who she is. Perhaps, then, more than her likability, this is the real sacrifice she makes on the altar of her truth.

Wurtzel places her hope and faith in psychiatry as a technological panacea to ward off (or at least abate) the recurrence of symptomatic manifestations, to reduce the pain and suffering associated with her mental disorder, and to allow her to return to some normative form of functionality. Narratives like Wurtzel's:

> …exist alongside a hope that the person can retain their dignity as a service user in the face of the stigma and shame still associated with living with mental health problems. The dilemmas that these contradictions create are held in place through the faith that service users are required to display as part of the narrative sequence of recovery. Within the recognizable and repeated narratives we witness in popular culture and autobiography, the hero is one who is able to accept their diagnosis ('I have depression'), and recast themselves as an object of hope and faith. (Blackman 2007, 8)

Wurtzel does adhere to this recognizable narrative, and in doing so creates a standpoint from which to make her experiences intelligible both within and between selves. As Wurtzel's story illustrates, from within the psychiatric paradigm she is able to come to terms with her experiences, make sense of her world, and see this reckoning as a restitution narrative or story of recovery (see, for example, Frank 1995). Her confession facilitates a sort of narrative cohesion and continuity. The rough chaotic edges have been rounded off, enhancing the ability of others to empathise with her (even if only through relating to her "case"). Projects like Wurtzel's retrospective reconstitution of her depression qua chemical imbalance thus create an accessible point of entry into the experience of mental disorder.

As Wurtzel's book became a national bestseller, and was also made into a major film, the uptake for her story has been significant. In the afterword to the 1995 edition, Wurtzel recounts how shocked and happily surprised she was at the extent to which people reached out to her with their own personal experiences and expressions of gratitude (PN, 354). She was also "unprepared for some of the things people wanted to know after they read *Prozac Nation*" (PN, 354). First, why had she written the book? At one point she suggests "I had tried very hard to get away from thinking or feeling depression in all of my professional endeavours, but it just kept creeping up, over and over again, like a palimpsest, a text hidden beneath whatever else I was working on that *refused to remain submerged*" (PN, 355 emphasis added). Something deep inside her, indicative of and pervading her very being had been repressed and must be made to speak. The second question was almost invariably, “*What on earth makes a woman in her mid-twenties, thus far of no particularly outstanding accomplishment, have the audacity to write a three-hundred page volume about her own life and nothing more, as if anyone else would give a shit?*” (PN, 355 emphasis in original). Her rationale:

> In effect, if *Prozac Nation* has any particular purpose it would be to come out and say that clinical depression is a real problem, that it ruins lives, that it ends lives, that it very nearly ended *my* life… I wanted this book to dare to be completely self-indulgent, unhesitant, and forthright in its telling of what clinical depression looks like… I wanted to be completely true to the experience of depression–to the thing itself, and not to the mitigations of translating it. (PN, 356 emphasis in original)

This quote illustrates Alcoff’s point (albeit somewhat crudely) that there is something of value in the detailing of one’s personal experiences, especially those that tend to exceed language. I take this point quite seriously especially where narratives of mental disorder are concerned, as there is something distinctly significant about the telling of the actual feeling of it. At the same time, however, I am concerned with the propensity of the majority of these narratives to not critically assess the ideological systems that constitute those experiences as a salient category of identification, and mark them as deviant. And questions such as the ones above illustrate McWhorter’s claim that there is no endpoint to confession (BP, 28). One will be made to speak again and again. Wurtzel’s psychic life had become an epistemic object, something to be known. As a solidified object of knowledge, a specific and definitive set of knowledge claims are assumed possible. In other words, with more probing we can come to know the entirety of the thing in itself. Similarly, Wurtzel's responses to these questions illustrate how confessional narratives of this genre naturalize the identifications and categorizations within which they frame experience. They aim to expose the real problem, *the thing itself*.

The extent of the response Wurtzel received, I suggest, is due in part to her conformity with the newly sanctioned sites, practices, and rhetorical discourses in which mental disorder is made to speak. As Foucault argued, during the Victorian era, the scientific authorization of confessional events and personal reflections was accomplished through a number of different processes that worked to reformulate the evidentiary value of personal experience (HS1, 65-67; see also earlier discussion in chapter two). These processes are no less operative today. Formalized examinations and questionnaires, clinical codifications, mediation and interpretation by authorized examiners, and the medicalization of confessional events continue to confer foundational status upon personal experience. Wurtzel's narrative passes through these different processes, especially in her adherence to the biomedical model as an explanatory framework. Her narrative is socially authorized because it conforms to the dominant style of thought in circulation regarding mental disorder, and she willingly submits her experiences to mediation by psychiatric discourse. She is, then, in some respects, *rational* about her mental disorder.

Allow me to reiterate at this point that I am concerned not so much with the reality of mental disorder, or whether or not stigma exists, but rather with the forms of knowledge that stigma discourse produces and the relations of power that result. In looking at Wurtzel's narrative my goal has not been to assess the veracity of her claims, but rather to interrogate the historical processes and dominant discourses that structure and inform her experience. As Wurtzel's narrative reveals, one can still question how one's personal history, family, environment, and/or biology has contributed to one's experiences without entering into any real interrogation of the category of experience itself. In her uncritical adherence to the biomedical model and devout recourse to personal experience alone, the trajectory of her narrative forecloses the possibility of exposing the disciplinary networks of power/knowledge that mark mental disorder as an epistemologically salient and socially stigmatized location.

As with the scandalous literature of the anonymous Victorian gentlemen known only as "Walter," introduced in chapter two, confessional narratives such as Wurtzel's can be read not so much as speaking out against the stigma of mental disorder, and the forces that would have it silenced, but rather can be understood as partaking in the sites created in which to make one's mental disorder speak. Likewise, as in the case of Jouy, the simple-minded man from the village of Lapcourt, these narratives come to represent more than just an encapsulated moment of time or personal experience. They come to signify the *kind* of person the author is – bipolar, schizophrenic, borderline personality, atypical depressive. Mental disorder has been made a matter of public interest, a matter that must be put into words, and made to speak exhaustively. As with these earlier confessional accounts, these autopathographies are a product of the very hypothesis that they seemingly stand in opposition to. In other words, they do not work so much to speak out against the repressive forces that would have them silenced, but rather their authors are participants in the new sites created in which to make their disorders speak under the newly sanctioned rationale for doing so. And the ways in which they make their experiences speak deeply influences the experiences of how they are heard.

Receiving Experience

The two texts I have been working with – one critical, the other confessional – work to facilitate different sorts of experiences for readers. As described above, Wurtzel was very much concerned with establishing knowledge claims about depression. The book was written in hopes that she could give "a face to what depression really looks like" (PN, 357). For many people, she accomplished this. As Wurtzel writes:

> I never expected to get more letters in the last several months than I had cumulatively received in the previous twenty-seven years. I never envisioned the number of people who would come to readings, some bringing me CDs, tapes (thanks for all the great Springsteen bootlegs), worry dolls, vitamin pills, herbal remedies, books of Rilke, tubes of ChapStick, even their own diaries. (PN, 354)

Many readers obviously responded positively to her narrative, wanting to care for her, and reciprocate with their own confessions of mental disorder. Wurtzel clearly saw the sharing of her experiences as a means to expose the real problem, the thing in itself. And in turn, this is how readers responded. *Prozac Nation* offered them facts about Wurtzel, facts about depression, and facts about themselves. And surely these facts were comforting, and offered solace to others experiencing similar struggles. Nevertheless, there is something starkly different between this sort of reception, and the sort of reception that McWhorter received in response to her anti-coming out story. This difference is indicative of the effects that experience telling can have on the solidification or transformation of subjects – authors and readers, speakers and hearers.

In her reading of Foucault, McWhorter suggests that what was of prime importance was not so much the knowledge claims he made, so much as the effects of these readings, what they tended to do, the sorts of transformation they provoked (2001, 119). In the process of writing her own book, McWhorter had a similar sort of experience. It was increasingly difficult for her to maintain "hard and fast" arguments. In a sense, the writing became more about the process and practice of writing itself, about what this was doing to her, the transformation it instigated, rather than a disciplined adherence to the strictures of philosophical argument and striving for definitive conclusions. McWhorter suggests that those who read her text undergo a similar sort of experience. She writes:

> I think that is why readers contact me, not when they reach the end of the book but while they are in the midst of it. They respond to

> what it does to them and what they begin to do with it, and in a very important sense it does not matter how the book concludes or even what it claims. The book's work is in the reading, not in the knowledgeable concluding. (McWhorter 2001, 119)

Her experiences are not shared in order to impart some sort of transhistorical truth. They are not taken at face value. She actively interrogates the categories of identification into which many of her experiences have been shoehorned and labelled. In this way, her story is a form of social critique. As Oksala states of Foucault's scholarship:

> In order to function as a form of social critique his analyses must contrast the subjective with the objective and reveal a problematic and irreducible gap: the normative and dominant discourses must be juxtaposed with the subjugated knowledges in order to reveal the former as pathologizing, criminalizing, and moralizing discourses of sexuality, for example. (2011, 219)

In performing a similar sort of juxtaposition, McWhorter reveals the gaps and fissures between the objective and subjective, in which both she and her readers locate the potential for personal and political transformation; gaps which quite possibly open up "a broader range of possible experiences of sexuality – experiences currently unavailable or even unimaginable – constructed through a new or different set of cultural norms" (Oksala 2011, 214).

Thus the ways in which we relate to and relay our personal experiences can have a profound influence on the construction of particular sorts of subjectivities and sets of political possibilities. Critical narratives like McWhorter's open up spaces to recognize identity as fluid and shifting, offering insight into the potential for change. Confessional narratives like Wurtzel's, on the other hand, solidify individuals into naturalized categories of identification, often foreclosing the possibility of envisioning things in any other way than they already are, always already have been. Wurtzel's coming out narrative does not represent a radical break or historico-political rupture with the stigma hypothesis but is derivative of it, reproducing the ideological systems that make her experience possible.

Unfortunately, it is the latter of these two narrative forms that dominate contemporary public discourse concerning mental disorder. The detriments associated with them reveal the risks involved in uncritical acceptance of personal experience, and illustrate why the set of feminist concerns regarding experience ought to be injected into the field of philosophical psychopathology where categories of identification (i.e. psychiatric diagnosis) and personal narratives form a substantial part of the field's analysis. The interesting piece here is that there are still many people who would say that persons with mental disorder are incapable of authoring their own experiences. Thus there is even more at stake here because the concern moves beyond the knowledge-making claims embedded in articulating one's experiences, to the bigger question of whose experiences, and which speakers, are recognized as credible epistemic agents, even when it concerns their own experiences.

Chapter Six

Coming out Mad: Or Why I'm Anti-Anti-Stigma

> The stigmatized are fully expected to be gentlemanly and not to press their luck; they should not test the limits of the acceptance shown them, nor make it the basis for still further demands. Tolerance, of course, is usually part of a bargain (Goffman 1963, 120-21).

Prozac Nation, in its adherence to a scripted recovery narrative and a scientifically authorized vocabulary, is exemplary of the sort of confessional narrative published in the 1990s. Its success as a novel and a major motion picture is indicative of its broadly positive reception in the public domain. In many respects, Wurtzel became, and remains, the poster child for depression. During this same period of time, however, alternative narratives of encounters with psychiatric diagnosis and treatment were also on the rise (see, for example, Clover 1995; Shimrat 1997). Issuing from members of the consumer/survivor/ex-patient (c/s/x) movement, these narratives speak in opposition to the dominant psychiatric narrative. For members of the c/s/x movement, "…the constraints of the mental health system and standard treatment practices are the problems that require solution, rather than problems posed by their 'mental illness' and their 'sick' selves" (Morrison 2005, ix). Standing in opposition to the reductionism and damaging effects of psychiatric identification and classification, these narratives have not become bestsellers. They have not been translated into major motion pictures.

Trust and epistemic authority are often conferred in accordance with the social and institutional norms and structures of a given context (Fricker 2003,166-72). For the project at hand, the granting of epistemic authority can be artificially broken down on two different levels. First, epistemic authority can be granted or more readily ensured when one speaks within the terms of reference of dominant styles of thought. Those conforming to dominant narrative scripts are more likely to have their experiences received as truth-revealing. Second, speakers who possess emotional, behavioural, and/or cognitive traits falling within the socially anticipated normative ranges are more likely to be received as credible agents, when compared to those in possession of non-normative traits. Thus, when speakers actively resist dominant styles of thought, or are dispossessed of the emotional and cognitive characteristics of "the good informant", they risk being disqualified as credible agents.

Because persons labelled with mental disorders already possess characteristics that society deploys to bring into question the veracity of interlocutors' experiential claims, when challenging the dominant style of thought of biological psychiatry, activists risk further threatening their already compromised credibility. In their failure to conform to the dominant psychiatric narrative structure, activists are more liable to be read as especially mad, or especially incapable of saying what madness is. Their experiences are less likely to be read as truth-revealing, and are more likely to be dismissed as irrational, misguided, and/or delusional. Consequently, c/s/x and Mad Pride activists are often thwarted in their attempts to speak out against the traumas endured as a result of enforced psychiatric treatment, oppressive mental health law, and/or social stigmatization.

My argument that narrative overdetermination constrains resistant politics is not meant to suggest that any form of narrative overdetermination will necessarily constrain any resistant politics. Indeed, narrative (over) determination is unavoidable. Rather, I am saying something contingent and specific about how the biomedical model and the autopathographies it spawns function to inhibit a certain kind of psychiatric-resistant politics, a constraining effect that is properly conceptualized as a form of epistemic discrimination. In this chapter, I argue that biomedical concepts of mental disorder, and the narrative logic they prescribe, function to undercut fair assessments of the credibility of c/s/x and Mad Pride activists. As a result, activists are routinely denied advantages accrued by socially authorized truth-tellers, a category in which I include those persons, like Wurtzel, who readily internalize and self-identify with psychiatric discourse.

I begin with an overview of the consumer/survivor/ex-patient and Mad Pride movement, in order to offer a brief glimpse into its history, diverse goals and activities, and its politically broad range of members. I then undertake the challenging task of engaging with narratives of the movement's members. As there is no single narrative that offers an exemplary model with which to work, I have culled together pieces from a number of different authors. As a result, this particular section is somewhat disjointed in its effects. In many respects, this is a reflection of the narratives themselves, and I want to represent these narratives in their diversity as faithfully as possible. My goal here is to illustrate how these authors resist the dominant psychiatric narrative, and the forms of identification and confessional practices it entails. I then proceed to illustrate how these narratives, and the goals of the movement at large, are often dismissed as irrational and misguided, and sometimes denounced as dangerous and delusional. Embroiling themselves between a politics of the emotions on the one hand, and a politics of rationality on the other, activists assume the added risk of further undercutting their epistemic authority and capacity to self-determine. I argue that a form of epistemic discrimination underwrites these risks, wherein prejudicial attitudes unjustifiably diminish the credibility of activists' testimonies -- what Miranda Fricker terms "identity-prejudicial credibility deficit" (2007, 28).

In contrast to confessional narratives like Wurtzel's, the narratives of c/s/x and Mad Pride activists do represent a rupturing with the stigma hypothesis. These narratives illustrate activists' refusal to uncritically self-identify with processes of psychiatric classification, and their resistance to and co-optation of confessional practices. Because it is largely due to the influence of anti-stigma campaigns grounded in biomedical models of mental disorder that function to constrain these sort of mould-breaking counter-narratives, I conclude that I am anti-anti-stigma. Current mainstream tactics to target the stigma associated with mental disorder, while laudable in their goals, ultimately function to inhibit other forms of experiencing and engaging and understanding madness.

The Consumer/Survivor/Ex-Patient and Mad Pride Movements

The c/s/x movement is generally understood as a continuation and broadening of the challenges raised in the 1960s and 1970s, when harsh critiques of psychiatry were being meted out.[25] The movement consists of a broad range of individuals and viewpoints, organizations and political tactics. As the name suggests, some members are mental health service users, others position themselves as survivors of psychiatric treatment in order to highlight what they consider to be the unjust and dangerous practices of psychiatry (e.g., involuntary confinement and/or treatment), while others simply identify as ex-patients. The movement is thus quite varied in its membership base, and as a result, individual positions regarding psychiatry range from the more conservative to the more radical. And in referring to "psychiatry," members of the c/s/x movement are speaking specifically to "the standard biomedical and psychopharmacological models of practice that shape the mental health system and are generally used by psychiatrists and ancillary mental health practitioners" (Morrison 2005, ix). Thus, in terms of positioning along the political continuum, on the one hand, some members more readily accept the mental health system, and are more concerned with issues of informed choice and being in greater control of the sorts and range of treatment options available. On the other hand, more radical members resist all forms of psychiatric identification and treatment, and actively engage in speaking out against the dangers associated with an institutional system that the contend pathologizes human emotion and exacerbates rather than alleviates psychological

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[25] For a full account of the historical background of the c/s/x movement, see Morrison (2005, 57-97); Reaume (2002).

distress. Thus generalizations regarding the movement are difficult to make. Nevertheless, there are some collective core goals towards which all members are generally thought to orient themselves:

> The movement claims that: (1) psychiatrized individuals must have an authorized voice in their treatment and the system of care; (2) they must have access to information and knowledge related to treatment decisions, legal rights, and other issues; (3) they must have protection of their right to freedom from harm; (4) they must have the power of self-determination; and (5) they must have access to choice in their treatment and their lives. In summary, the c/s/x movement claims that psychiatrized persons should have the same rights as any other human being. The fact that the movement's members have taken different routes in advancing these claims illustrates that it is in fact a grassroots movement that responds to local issues and needs, to the vagaries of politics and resources, to the quirks and passions of its members, and the pressures of human experience. (Morrison 2005, 79)

Thus whatever paths individual members choose in their pursuit of these goals, the intention is to provide an alternative viewpoint, a counter-narrative to mainstream biomedical models of psychiatry.

For some, part of this activism manifests itself in the growing Mad Pride movement, which "echoing the tactics of the Black Power movement, the Feminist movement and the Gay Rights movement of earlier decades, has tried to reclaim the old language of madness, attempting to reverse the stigma of formerly pejorative words" (Perring 2008, 1). Mad Pride aims to celebrate "the creativity, strength and resilience of the human spirit. It provides an opportunity to empower psychiatric survivors and raise public consciousness about human rights through various activities such as art, theatre, music, poetry, protests, vigils and more" ("Mad Pride Campaign" n.d.). Whatever the range of goals one might endorse, Mad Pride activists generally agree upon the need to recast how persons with mental disorder are understood and treated. As stated by Will Hall, host of Madness Radio:[26]

> Mad pride is about people talking about experiences that we haven't talked about. It's about people coming out of the closet with our extreme emotional states, with our wild energies, with our intense sufferings, with our joys; a whole range of experiences that we go through that get identified as diseased and disordered, and then rethinking that and renaming that ...the mad pride movement is trying to challenge the official story about what mental health is all about... ("Mad Pride," July 2009)

Thus the intention behind Mad Pride is not to blot out or deny the differences in the emotional and cognitive processing of the mad. Rather these differences are to be reconfigured and re-valued. These differences are not illnesses, but "dangerous gifts" to be celebrated for the contributions they make to our understanding of the human condition, and to the flourishing of mental diversity.

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[26] Available on-line at: http://www.madnessradio.net/

One of the first events to celebrate Mad Pride was the "Psychiatric Survivor Pride Day," held in Toronto, Canada on September 18, 1993 (Reaume 2008, 2). Since 2000, the Toronto event has been celebrated in July to correspond with International Mad Pride Day, has expanded its festivities and events from a single day to an entire week, and has renamed its celebration "Mad Pride."[27] Typical events include poetry workshops and readings, film screenings, discussion forums, stand-up comedy, and theatre performances. There is also the infamous bed push, in which groups of dressed-up individuals push a hospital bed down the streets. This bed usually has a mannequin strapped down in four-point restraints. This performance is meant to evoke images of escaping from the asylum.[28] The city of Toronto officially recognizes Mad Pride Week, and in 2010 Mayor David Miller proclaimed:

> WHEREAS there are men and women around the world, from all walks of life and of all ages, who face mental health difficulties and challenges during their lives.
>
> Emotional trauma has profound consequences on the quality of life of individuals and families and an economic impact on society.
>
> Service organizations and agencies in our community raise public awareness about the discrimination and stigma attached to mental

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[27] See, for example, Crazy Talk's (a vlog by the Mad People's Video Committee) video of Toronto's 2009 Mad Pride parade, including thoughts from participants on what Mad Pride means to them (2009).

[28] MindFreedom offers tips for hosting a successful Mad Pride event, including how to stage a bed push, how to "Screen the world for normality," and how to build giant props of pills and hypodermic needles ("How to Host" n.d.).

> health. The promotion and awareness of mental illness is often achieved through the works of artists, educational endeavours and other supportive actions and efforts.
>
> The fight for human rights and the elimination of discrimination and injustice help protect the rights of psychiatric survivors and other marginalized individuals, thereby empowering and improving their sense of well-being and quality of life.
>
> We must all commit to the values of acceptance, self-determination and respect of individuality, and develop strong beliefs in the intrinsic worth and dignity of every human being.
>
> NOW THEREFORE, I, Mayor David Miller, on behalf of Toronto City Council, do hereby proclaim **July 12 - 18, 2010** as "**Mad Pride Week**" in the City of Toronto and encourage all residents to support equal rights for everyone. (Miller 2010)

Thus the Mad Pride movement and its international events are receiving increased attention, including that of mainstream media. *The New York Times, Newsweek Magazine*, ABC-TV, and CBC radio have all featured coverage of the Mad Pride movement.[29] While the broad reach and popularity of these sources would suggest that there is a growing awareness of the movement, its various goals and convictions remain contested. This resistance includes many people with serious mental illnesses who "do not take pride in having what they see as a disabling

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[29] See, for example, Glaser (2008); "Listening to Madness" (2009); Robinson and Rodrigues (2009); and "Mad Pride" (2009).

disease, and they want to be rid of their condition. …One can take pride in one's fight against the disease or one's dealing with the associated suffering, but not in the disease itself. To take the Mad Pride movement seriously, it seems that it has to propose an *alternative* view of what we call mental illnesses" (Perring 2008, 3-4 emphasis in original). The narratives of c/s/x and Mad Pride members provide such an alternative.

Consumer/Survivor/Ex-Patient and Mad Pride Narratives

As suggested earlier, members of the c/s/x and Mad Pride movements are vastly diversified in terms of their relationships to psychiatric practice and treatment protocols. Thus it is hardly surprising that narratives issuing from within the movement likewise represent a diversity of experiences. But there is more to it than simple differences in their ideological convictions and political commitments. There is grand variance in the narrative forms themselves. These stories range from those that I would suggest are written from within madness, to those which offer a bit more reflective distancing from their experiences but nevertheless remain quite chaotic, to others which, while quite subversive in content, seem to adhere to more normative narrative standards. In fact, these narratives vary to such an extent that I would venture to argue that they, like their authors, defy and resist any steadfast form of categorization. Nevertheless, in reading the stories of c/s/x and Mad Pride activists, one thing quickly becomes apparent -- these are not your average coming out confessional narratives.

It is not my intention here to make overly broad generalizations with regards to these narratives, or to represent them as monolithic in their commitments and struggles. Some members accept psychiatric nomenclature, while others do not. Some members actively pursue mental health services; others resist them at all costs. Nevertheless, for the sake of analysis I would argue that it is safe to make some basic claims about how they might be read as a whole. While there is no one exemplary model of this collection of narratives, across the continuum it is evident that they seek to resist the vagaries and dangers of confessional practices that Foucault and McWhorter warn of. Not only do they often resist self-identification with psychiatric classification, and abstain from contextualizing their madness as revealing something about their hidden essential natures, but also they often speak to the liberating effects of silence and alternative modes of non-confessional speech.

To begin, in contrast to Wurtzel who listed off rather clinically (and uncritically) the processes by which she came to be diagnosed with atypical depression, many activists query the grounds upon which they came to be labelled with a mental illness. Survivor Leonard Frank states:

> I was able to obtain a large part of my psychiatric records nine or ten years after I was released from the hospital. There was the medical examiner's report – just a paragraph – with a provisional diagnosis of schizophrenia. This report read in part that I had become asocial, had grown a beard, was not working, had become

> a vegetarian, and to use their exact phrase, “was living the life of a beatnik to a certain extent.”
>
> On that flimsy evidence, I was committed. I was put into a psychiatric prison, in effect, and kept for a period of 7 to 7 ½ months. (2001, n.p.)

Frank gestures towards the point that encounters with the mental health system are often precipitated by failures to conform to societal expectations and normative behaviours. This sentiment is echoed by many c/s/x and Mad Pride activists who resist being identified as a certain kind of person simply because they do not, cannot, or refuse to conform. As survivor Jody Harmon states:

> I'm a psychiatric survivor, and I don't use that term loosely. I have been stored in warehouses labeled hospitals. I have endured weekly lectures termed therapy. I have been zapped until my brain burns white. I have been held down, tied down, put down. I have had pills forced down my throat and needles plunged into my flesh. All this to make me 'normal,' a mold I will never fit. (2001, n.p.)

For many individuals, actively rejecting the sick role and the disciplinary measures it demands, is the only way to escape the damaging effects of psychiatric treatment on one’s bodily integrity, psychic well-being, and political worth. Survivor Victoria Gaines states this point very clearly:

> No thanks to this ‘mental health’ system, I haven't been in a psychiatric institution since 1998. How can you even trust a system that has willingly and viciously lied about you, locked you up against your will, taken you to court in order to force its will upon you, kept you drugged up on toxic, mind-numbing, body slowing, life-denying drugs, and created public records that will go down in history defining you as a violent, paranoid, delusional danger to yourself and others when you know that nothing could be further from the truth? (2001, n.p.)

Victoria openly questions the therapeutic value of psychiatric practice and treatment, and defiantly rejects the labels she has been dealt. For Victoria, the mental health system is a dangerous place to be, one in which her human rights and who she is as an individual risk continual violation.

Even those activists still engaged with the mental health system voice similar concerns with psychiatric categorization, and the hazards of uncritical self-identification with processes that would mark them as sick, and their experiences as symptomatic of their illnesses. For example, John, who has been living with a diagnosis of schizophrenia, states, “When it gets right down to it, the medical model is an insult to me. To say I have a diseased brain does not validate me. I have a complicated thought system, with different behaviours” (quoted in Luhrmann 2000, 267). John does not want his thoughts, actions, desires, and intentions to be dislocated from who he is. While accepting some of the terms of a biomedical model of mental disorder, he does reject the implications this has for how he is or is not received as a responsible agent. As Luhrmann states about John:

> John wants to be seen as a responsible person. He is not, he thinks, responsible for being ill. … And John does admit to having an organic problem. But he resists thinking about his schizophrenia as a disease because his schizophrenia affects his mind and he wants to think of himself as responsible for his choices, his ideas, his writing, his political work. He wants to be a trustworthy member of society. He wants to be seen as someone who admittedly has limitations but who within these limitations is reliable, reputable and upstanding. (2000, 283)

John works as a counsellor and facilitator of self-help groups. In contrast to those anti-stigma campaigns that seek to diminish attributions of responsibility, part of his work, as he sees it, is to reintegrate a sense of responsibility in those with whom he works. Their ability to function and be recognized as full citizens hinges upon their capacity to be understood as reliable and upstanding. However, given the ways in which the biomedical model pathologizes basic processes of the self, especially in relation to schizophrenia, it promotes the perception that persons so labelled are incapable of meta-reflection on their own mental states and experience – which is one definition of rationality. In other words, mirroring McWhorter’s earlier arguments regarding the reductionistic effects of sexual identification, one cannot be both diagnosed with schizophrenia and be received as a rational being.

Thus, in contrast to Wurtzel who readily adopts a medicalized vernacular and uncritically accepts the conditions of possibility of her experience, many activists, like Leonard, Jody, and Victoria, question how their experiences of psychic distress might have been otherwise if these experiences were responded to in a different manner. By no means is this to imply that these activists romanticize the struggles they face. Many are quite clear that they undergo periods of prolonged despair, and frightful episodes of instability. What they refuse to accept is that these difficulties are indicative of an illness that needs to be made to encapsulate the entirety of their beings, or for others that this means they need to be subjected to the disciplinary practices of biomedical psychiatry.

The other essential difference that narratives from the c/s/x and Mad Pride movement exhibit is an acute awareness of the complexities of confessional practices within the context of the mental health system. The complexities of confessional practices often materialize in relation to the notion of *insight*. The concept of insight within psychiatric practice is generally understood to denote the patient's ability to exhibit an understanding of their illness and how their illness affects their interactions in the world around them (Marková and Berrios 1992, 850). Narrower definitions suggest more explicitly that this understanding must correlate with the accepted views of psychiatry and mental health service providers:

> According to the psychiatric narrative, success in treatment is often measured by "gaining insight," which involves accepting psychiatry's explanatory model of one's problem or distress; this is

> logically followed by "treatment compliance" which ideally leads to recovery and a resumption of as "normal" (or at least "normally deviant") a social role as possible. (Morrison 2005, 112)

Thus it has been suggested that this sort of conceptualization of insight, "defines insight as social acquiescence" (Marková and Berrios 1992, 854). The use of insight in clinical psychiatry often complicates, from the outset, how protests of c/s/x activists are received. As Irit Shimrat suggests:

> As a mental patient, you don't just lose your credibility with other people; you're taught not to believe in or trust *yourself*. You're taught to doubt your own perceptions: they may be signs of your illness. It's especially bad if you don't think you're sick. That means you have no "insight" – the psychiatric term for agreeing with your doctor about what's wrong with you and what should be done about it. If you fail to appreciate the nature of your illness, you will be deemed incompetent to make treatment decisions. As the process of declaring you mentally incompetent, or incapable – carried out by psychiatrists, of course – allows other people to legally make decisions on your behalf, lack of insight can be grounds for drugging you against your will. (1997, 9 emphasis in original)

Resisting or conforming to confessional practices functions as a means of negotiating the complexities of a setting in which how one speaks and what one says has very concrete and tangible effects. In negotiating the terrains of clinical insight, two different strategies emerge, often occurring in one and the same move. On the one hand, many activists speak of coming to recognize that silence is best when hospitalized, acknowledging that in particular settings confessions and/or protests can be dangerous. On the other hand, activists recognize that confessional practices can be used as a means to further their own goals, whether this is to facilitate release from psychiatric detention or ensure continuation of disability benefits. Confessional practices are thereby resisted either through remaining silent about how individuals feel about what is happening to them, or through playing confessional games and deploying these tactics in subversive ways.

For example, survivor Janet Foner states:

> Seclusion felt like a complete nightmare. I was terrified beyond [belief], thought I was going to die or jump out the window – the window was tiny and barred. I felt like I was a spy in a spy story who was captured by the enemy and/or an inmate in a concentration camp during the Holocaust and that I was going to be killed any minute. My feelings may have been intensified by the huge amount of drugs. I was desperate to get out of there and screamed for help – a logical reaction, interpreted as "mental illness." *No one told me I had to be quiet to get out of there*. (2003, n.p. emphasis added)

Janet's words echo the sentiments of many who come to realize that keeping quiet is best, especially in a context where one's credibility is assumed to be lacking, and speaking out against the treatment one is receiving is often interpreted as symptomatic of their illness. Silence can be the pathway to liberation, wherein silence is configured and performed through enacting compliance.

This performative silence is what Victoria Gaines suggests is the hidden curriculum of psychiatric commitment:

> Everything I said was discounted, denigrated. My ex-boyfriend and my family members' lies were taken as truth and my truths were taken as lies or delusions or hallucinations and symptoms of my insanity. All my strengths—my enormous energy, confidence, intelligence, speed of thought and movement, attention to detail… ability to anticipate what people will say, etc., were taken as evidence of my manic-depressive disease. The angrier I got about being discredited and mistreated the more I was deemed insane and "labile." The more I expressed my spiritual beliefs (e.g., goodness triumphing over evil) the more I was diagnosed as manic, delusional, hallucinating and schizo-affective.
>
> After the 72 hours, I began to "demand" my constitutional rights, to meet my accusers, including my ex-boyfriend, and to participate fully in my "treatment" plan. Of course, I was denied.

> Due to my angry, loud contentiousness and refusal to back down from attempting to secure my human rights, I was eventually physically restrained and shot up with Haldol….
> They taught me well how to behave in a nut house. It's a lesson I will carry with me for the rest of my life. After the Haldol assault I learned real fast to *keep my mouth shut* around people like this "mad" psychiatrist. I was in terror: scared for my life and sanity. From then on I more than cooperated. *I kissed ass* and got the hell out of there as soon as I could. (2001, n.p. emphasis added)

Victoria illustrates how her actions and demands were consistently read as symptomatic of her mental illness, including her resistance to how she was being treated while institutionalized. Like Janet, she learned that silence was best, and that conforming to the disciplinary measures to which she was being subjected and playing their confessional games were ultimately her route to freedom.

One final important difference between c/s/x and Mad Pride narratives, and those conforming to the psychiatric recovery narrative, is that some of these narratives actively promote an alternative mode of truth-telling that steps outside the confessional practices of biomedical psychiatry, to offer a rhetorical space in which madness can speak. As the stories above suggest, for many c/s/x and Mad Pride activists the mental health system is not a place of healing, and for this reason a number of activists suggest that individuals are better off seeking the help and support of trusted friends rather than entering into psychiatric treatment. Some go so far as to suggest that the disciplinary measures of biomedical psychiatry ought to be resisted at all costs. As a result many activists speak of working to recreate social environments and support networks in which they are not defined as mentally ill.

This injunction to seek the support of friends rather than mental health professionals can be read as a means of subverting traditional confessional practices of psychiatry and entering into alternative modes of truth-telling and experience sharing. As Mariana Valverde writes, “Truth telling becomes confessional only under certain circumstances, in situations in which the institutional and cultural context and the speaker’s own analytical tools favour such a move” (2004, 83). Shifting the location of one’s truth telling and experience sharing to a different setting is an active gesture of resistance to the dominant biomedical model of mental disorder, and so too it can be an active gesture of reclaiming personal responsibility for one’s life.

For example, Irit Shimrat relays her experience of a psychotic episode in which she was convinced that someone was out to get her and that the only way she might be saved was to commit suicide. Interestingly enough, this occurred while in attendance at a mental health conference. Aware that she needed some sort of assistance and support, Shimrat asked one of the psychiatrists in attendance for help, the same woman that she was scheduled to interview for a radio program Shimrat was developing called “Analyzing Psychiatry” to be featured on CBC’s “Ideas” series. The woman replied that she was unable to help her due to scheduling. Reflecting on this, Shimrat states, “I was lucky. If she’d agreed to see me, I probably would have landed on some back ward in an Alberta mental hospital, completely dysfunctional on psychiatric drugs" (1997, 77). In the absence of other professional support, she sought the comfort of a friend also in attendance at the conference. Shimrat goes on to say, "I thought it was interesting that the first and second times I went mad, I got professional help – hospitalization and drugs – and stayed crazy for months, the third time I got help from a friend who wasn't scared because she'd been there herself – and it was over in a few hours" (1997, 78). Different responses led to different outcomes. Shimrat's friends and community continue to be her primary means of support. Nevertheless, she openly admits that:

> …it can be very frightening to let go of the belief that you're sick; to let go of dependence on doctors. Relinquishing responsibility for your life can be comforting and reassuring. And the idea that there's nothing wrong with your brain and that you need to figure out how to make your life better, rather than depending on experts to look after you, can be terrifying. (Shimrat 1997, 44)

This sort of refusal to enter into dialogue with the mental health system can be read as a form of intentional silence. Silence, then, not confession, can be the pathway towards personal freedom. As Chloë Taylor suggests, silence can be understood as "an alternative to confession, as a means to resist the disciplinary incitements to confessional discourse under conditions of coercion…" (2009, 194). The positioning of one's speech acts outside the medical domain and its dominant style of thought not only provides an alternative source of support but also offers an alternative to standard confessional practices and the ensuing disciplinary measures of biomedical psychiatry.

In resisting these processes of identification, etiological explanations, and confessional events, activists forego the processes of social authorization that would authorize their narratives as legitimate, credible, and rational. As a result, their testimonies are often dismissed as lacking insight. In other words, in contrast to Wurtzel, they are *irrational* about their madness.

Receiving Madness

As McWhorter states, “When you are admitted to a mental institution, you lose, among other important things, your credibility as a witness, your status as a knower” (2001, 117).[30] This loss of credibility often clings to the individual even if they are no longer institutionalized. This is exemplified in the cases of those individuals whose non-mental health related concerns are met with suspicion in the clinical environment once their histories of psychiatric treatment are disclosed (see, for example, Read and Baker 1996, 19; Wahl 1999, 72). In other words, a residual stigma lingers. One’s status as a reliable and trustworthy informant is tainted. This tainting is especially forceful and damaging for those who attempt to speak from the specific standpoint of one who was institutionalized, and do so in order to critique the psychiatric system.

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[30] A prime example of this is revealed in the results of the now infamous D.L. Rosenhan (1973) study, “On Being Sane in Insane Places.”

One cannot reasonably deny that in the pooling of our epistemic resources we must be judicious in whom we to choose to rely upon. We need to determine the characteristics of a good informant and whom we can take at their word. We must, on some level, then, be discriminating (Fricker 1998, 162). Much as we come to develop a sense of right and wrong, we undergo a sort of epistemic socialization during which time we learn a variety of cues and indicators that inform our judgments of speakers' credibility (Fricker 1998). These shortcuts allow for the spontaneity and fluidity of our credibility assessments. At the same time, however, the determinants of a good informant are deeply entrenched in the social mores of a given historical setting. As Fricker argues, "Our everyday, face-to-face testimonial encounters bring to bear a whole social consciousness in an instant and this creates a deep structural liability to prejudicial dysfunction in our testimonial practices" (2003, 164). As such, when judging the credibility of others, we run the risk of being discriminating not only in a pragmatic sense, but also in an oppressive sense.

One set of legitimate heuristics that we routinely rely upon in our judgments regarding the validity of a speaker's claims is the person's emotional performance (Fricker 2007, 125). We anticipate and expect a certain range of emotions; an excess or deficiency of anticipated emotions, or a display of unexpected emotions occasion doubts regarding the speaker's credibility. In some instances our emotions can and do impair rational judgment. However, this point must not be made at the expense of recognizing that many of our emotions are socially inculcated and defined. We are taught emotional responses appropriate to particular circumstances. We learn proper modes of their expression, and acceptable objects of their intentions. As such, our own emotional performances and our assessments as to the appropriateness of others' emotions are normatively prescribed. As Alison Jaggar, Cheshire Calhoun, and others have argued, these prescriptions work to "outlaw" certain emotions for certain social groups so that when enacted they are rendered deviant (Calhoun 1999; Jaggar 1989; Spelman 1989).

Consider anger for example. As Elizabeth Spelman argues:

> In western cultures there has long been an association of reason with members of groups that are dominant politically, socially, and culturally, and of emotion with members of subordinate groups. ...It has been argued again and again, in one form or another, that just in virtue of this association, rational types ought to dominate emotional types.
>
> But there is a striking exception to this assignment: while members of subordinate groups are expected to be emotional, indeed to have their emotions run their lives, their anger will not be tolerated: the possibility of their being angry will be excluded by the dominant group's profile of them. Women are expected to be easily given to sadness, say, or to jealousy ...but anger is not appropriate in women, and anything resembling anger is likely to be redescribed as hysteria or rage instead. (1989, 264)

Why might this be the case? Spelman suggests it is because anger is understood as always entailing some form of negative evaluation (1989, 266). In expressing my anger, I denounce a situation or the actions of another as wrong, harmful, dishonest, disrespectful, inappropriate, or the like. In staking this claim, I am holding the other accountable to a particular set of standards. In doing so, I assert, if only momentarily, my authority to pass such judgments on the other.

Conceptualized in this way, narratives and protests emerging from within the c/s/x and Mad Pride movements are potentially read as expressions of anger, in the sense that they too denounce a situation, set of practices, and/or institutional arrangements as wrong, harmful, dishonest, disrespectful, or inappropriate. Attempts are being made to hold others accountable to a particular set of standards, and speakers assert their authority to pass judgment on these others. Yet, like women's anger, the anger and protests of c/s/x and Mad Pride activists are subject to the same reinscriptions and dismissals:

> The capacity to be angry just doesn't fit in as part of a personality profile designed by dominant people for those they see and wish to maintain as subordinate to them. For it would mean both that the subordinates would have standards of conduct applicable to the dominants, and express and apply those standards; and that dominants would thereby be subject to the judgments of those they've deemed to be beneath them. (Spelman 1989, 267)

This is especially the case in the context of psychiatric practice given the notorious power differentials that have historically existed between practitioners and those under their treatment. Certainly this is not to overlook the point that anger, like other emotional states, "can be regarded as appropriate or inappropriate, reasonable or unreasonable, justified or unjustified, by others or by oneself" (Spelman 1989, 265). It is only to point out that the anger of c/s/x and Mad Pride activists is more likely to be dismissed as inappropriate, unreasonable, and unjustified. Their protests, when voiced both within and outside the institutional setting are often dismissed out of hand as dangerous and irrational (i.e., lacking insight) rather than sites of legitimate grievances.

Consider, for example, the controversy surrounding the sector of activists who reject the need for medication, and protest involuntary treatment and psychiatric detention.[31] These activists assert, "If it isn't voluntary, it isn't treatment" (Morrison 2005, 145). They suggest that enforced treatment is more rightly understood as a form of punishment. In response, many of the movement's detractors (NAMI included) argue that medical treatment is often central to preserving the well-being of persons with mental disorder and to protecting the safety of those around them.[32] This being the case, involuntary commitment is sometimes a necessary evil for persons lacking insight into the severity and dangerousness of their conditions. "C/s/x activists are, in turn, accused of

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[31] See, for example, a current case under dispute in which MindFreedom, an international organization promoting human rights in psychiatry, is currently soliciting support and political action on behalf of a Pennsylvania woman who is being subjected to forced outpatient psychiatric drugging (Walko 2012). See also (Morrison 2005, 145-47).

[32] For a further discussion of the significant conflict between NAMI and c/s/x activists see (Morrison 2005, 148-55).

encouraging the psychiatrized to 'die with their rights on' by maintaining their right to avoid unwanted treatment" (Morrison 2005, 146). As E. Fuller Torrey, M.D., from the [US] National Institute of Mental Health Neuroscience Center and founder of The Treatment Advocacy Center, puts it "The policies espoused by 'psychiatric survivors' have…led to a large number of non-survivors" (1997, 143).[33] Similarly, psychiatrist Dr. Sally Satel, author of *P.C., M.D. - How Political Correctness is Corrupting Medicine,* suggests that it is not the mental health institution that owes activists an apology for the abuses they claim to have been subjected to, but rather it is they, the c/s/x activists, who owe apologies to other mental health consumers for impeding "constructive treatments and policies" (2000, 46).

A full exploration of the complexities of the debate surrounding enforced treatment is beyond the scope of this dissertation. Nevertheless, the heatedness of the debate illustrates the point that:

> The medicalization of psychiatric culture is split between those who are constituted as objects of danger and threat and those who are constituted as objects of hope and sympathy. This ambivalence is kept in place through the predominance of biological psychiatry. It is positioned as the authoritative discourse, able to calculate risk

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[33] To make this point regarding the necessity for stricter outpatient treatment laws and civil commitment reforms, Torrey has compiled what is called The Preventable Tragedies Database, which catalogues "incidents involving an individual with a neurobiological brain disorder (usually untreated) as a victim or perpetrator of a violent episode" (n.d.). One can search the database using a number of different criteria including "person with mental illness killed in altercation with law enforcement," "Family member injured or killed," "Suicide or attempt," amongst numerous others.

> and danger and administer individuals accordingly. (Blackman 2007, 13)

Non-compliant individuals come to be read as risk factors to public health and safety. “The non-compliant subject is not only the person who fails to take their psychotropic medication, but also the person who is unable or unwilling to take up a particular relationship to their mental health difficulties” (Blackman 2007, 3). Those who conform to psychiatric culture are more likely to be heard, while in contrast, those standing in opposition to its authoritative discourse, the risky and dangerous ones, are more likely to have their anger marked as irrational and excessive.

The politics of emotions in which c/s/x activists are embroiled is further complicated by the fact that, at the institutional level, psychiatry has increasingly sought to embed its theories within a biomedical model of mental disorder, and establish its credibility as a scientifically objective enterprise.[34] These attempts have not been entirely successful. Psychiatric classification and treatment is still broadly contested. For example, recent proposed changes for the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (to be published in 2013) have met with fierce criticism and sparked heated public debate (see, for example, Carey 2012, n.p.; Greenberg 2012, n.p.). Proposals to remove the “bereavement clause” in relation to the diagnosis of “major” depression -- the clause that grants two months of grieving before it is considered clinically significant -- have been

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[34] This is not to suggest that the only means to establishing its scientific objectivity is through the uptake of the biomedical model of mental disorder. One might conjecture that other routes are indeed possible. It is only to point out that this is the route currently being most enthusiastically pursued for the sorts of reasons detailed in chapter three.

criticized for pathologizing normal human emotion; the consequences being that more individuals are likely to be diagnosed with “major” depression and medically treated as such. In contrast, proposals to narrow the diagnosis of autism have met with public outcry that restricted criteria will result in services and treatment being denied to those in need who might no longer qualify if proposed changes are implemented. Thus my point here is not to suggest that psychiatry has become an incontestable bastion of rationality or scientific credibility. Rather, I want to highlight the differentials in epistemic authority accorded to speakers coming from different positionings within psychiatric discourse when they wish to critique it. When experts within the field critique contemporary or shifting practices within the field of psychiatry, their concerns are met with higher levels of regard than when these same practices are critiqued by psychiatric-resistant activists.

While these continued mainstream debates receive epistemic validation, more radical counter-discourses seem to fly in the face of what are purportedly scientifically objective facts. As Gabriella Coleman argues, the ushering in of the biomedical model meant that:

> Now, to be rational meant to accept this model of mental illness and, as a close corollary, the treatment model it entailed: psychotropic drugs. To do otherwise was seen as a stark rejection of what was being presented as transparent and clear scientific evidence and would implicitly, though no less powerfully, recode a person as lacking in rational capacities. (2008, 350)

In other words, c/s/x and Mad Pride activists risk further threatening their already compromised trustworthiness when attempts are made to challenge the authoritative voice of psychiatric expertise. For those activists speaking from within an alternative narrative, not only is their testimonial credibility made vulnerable, given their inclusion amongst the ranks of the mad, but it is further compromised given the institution they stand in opposition to. To express one's anger is already deemed inappropriate. To direct it towards an established institution, one must surely be downright mad.

One of the possible effects, then, of resisting psychiatric identification, or attempting to revalue madness is the reification of one's madness qua unreason. In this way, Mad Pride and c/s/x activists alike are caught between a politics of emotion and a politics of rationality. Thus the double bind of the Mad Pride and c/s/x movements: on the one hand, protest makes public a series of evaluative judgments, the sort that persons labelled with mental disorders are denied the social authority to make. This transgression functions to reify psychiatric identities and confirm or exaggerate their madness as a mark of shame in the public eye. The danger exists that the irrationality of the mad is repeatedly reaffirmed, thereby reinforcing and perpetuating the social exclusion and segregation of the mad. On the other hand, if activists are fortunate enough to access the spaces in which to have their voices heard, and speak clearly to their principles and rights, chances are their madness will not be recognized at all. As Shimrat states:

> …when I spoke about having been locked up and how awful it was, people would be very sympathetic and say a mistake had been made in my case, as I obviously wasn't mentally ill. Even though I would explain that I had been as crazy as anyone ever had been, with all the classic signs of what is called schizophrenia, I don't think people believed me. (1997, 40)

Because clarity and reason stand in contrast to what are typically taken to be the defining features of the mad, such individuals are likely to be received as outliers or exceptional cases of "their kind" (Everett 2006, 65). The double bind of protest then is that activists are either considered entirely mad, and thereby are easily dismissed, or they aren't considered mad at all.

For those whose emotions as a whole are generally deemed inappropriate, or irrational, it is all the more easy to dismiss legitimate grievances as similarly inappropriate, irrational, and/or incredible. As a result, the expressed anger of Mad Pride activists is outlawed, and so too are their counter narratives. This dismissal functions as a sort of political silencing, which not only inhibits others from responding to and claiming responsibility for the past and present marginalization of c/s/x and Mad Pride activists, but also serves to legitimate their failure to do so.

Rupturing the Stigma Hypothesis

The narratives of c/s/x and Mad Pride activists show that if you do not conform to socially endorsed scripts then you are liable to be read as extra specially mad, or extra specially incapable of saying what madness is. Because we think of reality in terms of coherence, we are incapable, literally, of receiving the narratives of c/s/x and Mad Pride activists as epistemically reliable. This does not just have to do with the madness itself. It has to do with a failure to fulfil the prerequisites for representing oneself as a subject. For experience to be taken as foundational it must be structured in particular ways. These particular ways place the teller's experiences in recognizable arcs, and those arcs are structured by reason, not madness (unreason).

These stories of the c/s/x and Mad Pride activists are not confessional events seeking to reveal some hidden secret about their authors' true, essential selves. So too, they are not solely about providing a critique of psychiatric systems of identification and treatment. These are stories about how their authors became certain kinds of subjects. They are, in many respects, then, counter-narratives of their authors' own experiences. In other words, they provide alternative narrative forms and alternative rhetorical spaces in which madness can speak. In this way they might rightly be defined as testimonies. As Chloë Taylor suggests:

> Testimony is to be distinguished from confession, as Foucault defines it, because confession is about revealing the truth of one's

> inner self, whereas testimony is about changing the self and changing society…Confession exposes a supposedly hidden truth of the self, whereas testimony tells the truth about the past in the hopes that in the process this past will be surmounted and will not be reproduced. Testimony should not aim to reveal a hidden and essential truth of an inner self or of a given group. Rather, testimonials should bear witness to what has been or is, in ways which are self-conscious that this need not have been and need not be in the future, and that this is not specific or inherent to the testifying individual or to her group. Such speech should function as a process not of self-reification and discovery but of self- and social transformation. (2010, 188)

Mainstream anti-stigma campaigns wedded to biomedical models promote the sorts of confessional narratives exemplified by Wurtzel, and in the process entrench specific modes of conceptualizing, experiencing, and expressing mental disorder. The unifying and homogenizing aspects of this leads to a situation in which other ways of understanding, relating to, and living one's madness are not received as relevant to the broader range of issues at hand that extend beyond despair and suffering – productivity levels, loss of work days, overburdened healthcare systems. This betrays mainstream campaigns' general lack of consideration for different kinds of material conditions and institutional niches. When a middle-class, well-educated, professional, nice young woman like Wurtzel comes out as depressed she is likely to receive a kind of care and response quite different from those who might be street-involved or persons coming from less than well off socio-economic circumstances who present with similar symptoms.

So too do these campaigns, as I have argued, inhibit counter-narratives that call into question the conditions that make possible the reading of madness as a pathologized and stigmatized social location. The testimonies of c/s/x and Mad Pride activists, therefore, represent a rupture with the stigma hypothesis. In their form and content, they subvert the confessional practices of psychiatry, its sanctioned modes of speech, and its dominant style of thought. But because they do so, we don't know what to do with them. We want to impose some sort of narrative rubric on them, or demand they be accompanied by more rational theorizing to make them more politically useful. We are concerned with the facts of the matter, and not with what the narratives do, how they transform and contest naturalized categories of experience, deeply unsettling and challenging our perceptions of rationality, of wellness and illness, of support and care, and of difference. As Lynn Huffer suggests, "the experience of madness cannot be captured, and, even if we could capture it, to do so would be to betray it" (2010, 65). And yet this is what calls to speak out and break the silence would try to have us do, capture the experience of madness, codify it, make it a naturalized object of knowledge, break it into teachable moments. In the process much is lost, and perhaps what is lost is that which Huffer says we can never grasp hold of in the first place.

Conclusion

Contemporary anti-stigma programmes are to be commended for their efforts to improve the lives of persons with mental disorders. Premised on the notion that current speech forms surrounding mental disorder are punitive in their effects, these initiatives attempt to supplant this speech with a non-judgmental and fact-based language, and encourage persons with mental disorders to come out of the shadows and break the silence. Anti-stigma rhetoric has incited a discursive explosion, and when wedded to a biomedical model of mental disorder it compels us to speak in particular ways.

As I have argued, these anti-stigma initiatives enjoy a series of speaker's benefits. These benefits include the production of a site of scientific inquiry, epistemic authority for experts working in the field, the creation of a cultural location in which new identities are forged, and the fuelling of a significant hub of economic activity. These new forms of speech, however, also incur a series of speaker's detriments. First, emphasis on mental disorder as a biological disorder depoliticizes understandings of and responses to treating mental disorder, obscuring (although not entirely blocking from view) the broader social and environmental conditions that contribute to its trajectory and mark psychiatrized individuals as deviant. Second, when adopting the biomedical etiological paradigm, these campaigns precipitate new forms of iatrogenic stigma, and risk introducing other sets of stigmatizing and damaging beliefs, including perceptions that persons with mental disorders are of a different kind, and are inherently more dangerous and untrustworthy than the general populace. Taking both the benefits and detriments of these initiatives into consideration, I have argued that the conceptual alignment of silence with shame, and the wedding of verbalized speech to freedom and truth, misconstrues the political complexities of coming out as mentally disordered. What we can say (if we want to be heard) is largely shaped by the governing style of thought, and the ramifications of this telling re-entrench that style of thought and the problems associated with it. Simple exhortations to tell your story and tell it well are therefore, at best, misleading, and, at worst, risk reproducing the ideological systems they are trying to dismantle.

Popular uptake of scripted biopsychiatric narratives coupled with the proliferation of mass media coverage of mental disorder entrenches new modes of self-surveillance in the general populace, extending the reaches of biomedical power into once private and inaccessible spaces. The proliferation of psychiatric discourse under the guise of anti-stigma rhetoric has meant that no one is immune to its disciplinary measures, and their capacity to label, reinterpret, and govern our experiences. Through my analysis of Elizabeth Wurtzel's memoir, I have illustrated how confessional narratives adhering to the biomedical script are at once both enabling and constraining in their effects. Moving beyond this claim, drawing from Ladelle McWhorter and other feminist philosophers, I have also made a more specific point about how one dominant narrative form inhibits a particular kind of resistant politics. Not everyone is considered a reliable source of knowledge. Not all experiences count as evidence. Experience is generally only granted foundational status when spoken within certain terms of reference, and once channelled through socially sanctioned processes of epistemic authorization. Persons seeking to offer an alternative account of their experiences are thus often met with scepticism or disbelief, especially when not couched in philosophically nuanced or theoretically rigorous terms. The challenges of the consumer/survivor/ex-patient (c/s/x) and Mad Pride movements vividly illustrate these points.

In this dissertation, I have thus worked to show that contemporary mental health anti-stigma initiatives leave us with an impoverished and constraining alternative language in which to speak of mental disorder. If this is indeed the case, and I hope to have persuasively argued that it is, then where does this leave us? What does it mean to suggest that these initiatives are falling short, and in some cases potentially reinforcing the very ideologies they seek to undermine? I do not take my arguments here to suggest that these campaigns ought to be done away with. I do, however, want to suggest that we carefully consider what other options we have in our search for alternative, less punitive forms of speech. What might these alternatives look like? Are they meant to supplant or supplement the current initiatives as they stand?

I recognise that anti-stigma campaigns have shifted how we think about and respond to persons with mental disorders in positive ways. Likewise, I acknowledge that they have opened up a space for a broader range of debate. Linda Morrison has argued that the increasing dominance of the biomedical model of mental disorder in the 1990s was, in part, responsible for the resurgence of the c/s/x movement (2005, 90). I want to suggest that something similar is happening now as a result of the global anti-stigma movement. Placing stigma in the foreground of our conversations about mental disorder has slowly worked to create a platform from which more marginalized individuals and groups are able to make their voices heard. At this point in time, the attention that the c/s/x and Mad Pride movements are receiving is still quite mixed. Nevertheless, one can acknowledge that at least their claims are beginning to be debated in public forums.

The discursive explosion surrounding mental disorder, coupled with the plethora of injunctions to make one's disorder speak in an increasingly broad array of confessional sites have worked to crystallize the experience of mental disorder, distil it down to a series of fact sheets, and generate an overdetermined narrative script. Yet the increasing presence of the c/s/x and Mad Pride movements reveals that the dominant discourse is not totalizing in its effects. Rather, the momentum building behind these movements is not occurring despite this forceful discourse, but because of it. C/s/x and Mad Pride activists' experiences do not seamlessly align with the touted facts of mental disorder, and it is precisely these gaps between the dominant discourses of mental disorder and what activists assert their experiences to be that the counterattack is made possible. Granting this, we can recognize these mainstream initiatives (problematic as they might be) as an important first step towards a more nuanced and inclusive conversation. Thus it is not necessarily the case that they need to be done away with, but there does need to be a stronger critical element added to them. I have argued that many of these campaigns imply that speaking out is the way to target the stigma associated with mental disorder. Their strategy is twofold: reducing punitive forms of speech, and encouraging persons with mental disorders to break the silence. It is the latter of these two goals that has been the primary focus of this dissertation. To identify potential strategies of counterattack, I therefore suggest that we ask what these mainstream anti-stigma campaigns themselves remain silent about. What are they not saying, and who or what is silenced as a result?

The wedding of these campaigns to a biomedical medical of mental disorder has worked to foreclose interrogation of categories of identification and classification, and the crystallizing effects they have. They do not question the conditions of possibility of these categories, the discourses that surround them, how they structure and influence the experience of persons with mental disorders, or, for that matter, why this category "persons with mental disorders" is of social and epistemological salience. Likewise, as I have argued, mainstream campaigns work to outlaw (although not entirely silence) the narratives of those persons seeking to offer a psychiatric-resistant narrative. Echoing these critiques, Kimberly White has criticized the Mental Health Commission of Canada's anti-stigma campaign on the grounds that its official language focuses exclusively on "consumer/user," to the exclusion of other alternatives like "survivor/consumer." She argues that:

> this indicates an official rejection on the part of the MHCC to the anti-colonial resistance of mad peoples and survivors to be recognized as self-determined, to locate themselves in culture, to reclaim their

> histories and assert a politics of identity that reflects their experiences, as mad or as 'survivor/consumers.' (White 2008, 2)

Lacking in these campaigns is any sort of genealogical account of madness qua mental illness.

I envision the addition of a genealogical account to these campaigns as featuring two primary elements: 1) a broadened and more critical account of the medical and social history of psychiatrized individuals, and 2) an active engagement with members of the c/s/x and Mad Pride movements. The goal in doing so would be to move beyond a simple resistance to the punitive forms of language that circulate around mental disorder, towards mounting what McWhorter terms *a counterattack* (BP, 193-227). A counterattack aims to expose the limits of dominant discourses, the contingencies of purportedly ahistorical and natural categories of identification, and the networks of power holding them all in place. As McWhorter suggests, "…sometimes historical events, recounted by those whose voices were almost suppressed rather than by those whose interpretations won out, can help us see the contingency of many of our beliefs" (BP, 199). Thus one proposed counterattack strategy is to incorporate the counter-memories of those persons who are marginalized by mainstream anti-stigma initiatives.

As a working illustration of a counterattack rooted in the deployment of counter-memories, I offer the example of the tours of the brick wall constructed in 1860 by the unpaid labour of psychiatric patients of the former Toronto Asylum at the now Centre for Addiction and Mental Health (CAMH).[35] Geoffrey Reaume, activist and York University professor, has been offering guided tours of the wall since 2000.[36] Given his own past experiences as a psychiatric patient, for Reaume, "this tour is both historical and personal" (Reaume n.d., n.p.). These tours and Reaume's research are the focus of a mini-documentary, entitled *The Wall* (2006), commissioned by the York Institution of Health Research. Two minutes in length, this video features images of etchings made in the brick wall by patients past (including one section where the words "Born to be murdered" have been chiseld), historical drawings and photos of the Asylum's buildings and grounds, current photos of CAMH, and video footage of Reaume conducting the wall tour. In a voiceover, Reaume describes the etchings, and the symbolic significance of patients "bricking themselves in." He briefly describes how the unpaid labour of psychiatric patients was institutionalized in the western world and justified as a form of "moral therapy," and how it is often the architects who are acknowledged for their designs to the exclusion of recognizing those whose efforts actually went into constructing the wall. He suggests that the wall represents the abilities of persons with mental disorders, past and present, and how the stories of the people who lived, worked, and died behind these walls can be used to fuel and advance contemporary claims to social justice for persons with mental disorders.

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[35] Toronto's Centre for Addiction and Mental Health is Canada's largest teaching hospital in the area of addictions and mental health, and one of the world's leading research centres in this area of study.

[36] These historical tours are based on Reaume's doctoral research, later developed into *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*. Toronto: Oxford University Press, 2000.

While it is most often the case that it is the architects of different structures that are given praise and not the individuals who constructed them, in this instance, this point takes on a greater level of significance. First, this lack of recognition reinforces misperceptions that psychiatric patients are not skilled. Giving recognition where it is due, “is a way of linking past exploitation of patients’ abilities with current barriers to employment for people with a psychiatric history” (Reaume n.d., n.p.). Through emphasizing the feats of these unpaid labourers, “this wall can help to challenge these contemporary prejudices by its very physical existence, quite unlike its original purpose that served to stigmatize those who lived behind these very same walls not too long ago” (Reaume n.d., n.p.). In other words, it can help break down the mutually exclusive and opposing categories of identification, wherein one can only be read as either skilled or mad, but never both. This is especially important in relation to individuals who have been institutionalized, arguably the most stigmatized of persons with mental disorders. Second, the constructing of brick walls can hardly be justified as a form of “light labour” prescribed by moral therapy (Reaume n.d., n.p.). Highlighting this point brings attention to practices that would now be condemned as inhumane or unjust, and reveals their contingency when presented as artifacts of their time. Different periods give rise to different ways of thinking and living. From this perspective, tour attendees are offered an alternative viewpoint from which to reflect upon contemporary medical treatments and social practices, creating potential glimpses into how they too are products of their historical context.

This juxtapositioning of past and present, however, might just as easily work to reinforce notions of progress, and further entrench contemporary dominant psychiatric discourse. The counter-memories of c/s/x and Mad Pride activists can aid in tempering these otherwise untoward potentialities. On the wall tours psychiatrized and non-psychiatrized bodies come into close contact, and engage with one another. Past and current patients often share their experiences and memories along the way, many of which challenge and expose the limits of psychiatry's normalizing discourses. While this can sometimes lead his planned tour astray, Reaume suggests that:

> it is better to not interfere by trying to silence people which would be hypocritical in the extreme. Better to be upstaged than to tell someone who has been silenced more times than I could ever know, when to be quiet, especially when this is their home, not mine. …A wall tour is not just the past, but it is about what people think of this place and people who live here today, since it is both a historical site and an active psychiatric facility. (Reaume n.d., n.p.)

The wall tours thus create a setting in which counter-memories can be told and heard amongst an otherwise unlikely group. And "It is when we counter-remember, when we notice the effort toward erasure, that something new may come into play" (BP, 207). With this something new, alternative ways of thinking, relating, and living are made possible.

In attempts to give voice to persons with mental disorders and transform the language in which we speak, many anti-stigma initiatives have functioned to outlaw the voices of those seeking to offer a counter-discourse. This betrays a lack of regard for those who do not seek to have deviance normalized, but rather who wish to have their differences and identities affirmed. The wall tours illustrate how incorporating historical accounts of madness and giving voice to the counter-memories of c/s/x and Mad Pride activists can work to improve current anti-stigma strategies. To move beyond simple resistance to “the stigma of mental disorder,” and mount a counterattack on the normalizing effects of both psychiatric *and* anti-stigma discourses, activist voices need to be engaged in this ongoing conversation and not further subjugated because of it.

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