CARE AS SURVEILLANCE: FROM THE STRUCTURAL TO THE INTERPERSONAL

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Abstract

We exist within a medical paradigm where our bodies are conceptualized as constellations of data, and our medical care is widely reduced to the comparison, through surveillance, of that data against an idealized normative body. This paradigm of surveillance as care alienates us from our own bodies and has been utilized toward broadly oppressive ends. However, it is not unique to the medical sphere. Rather, surveillance as care cannot be disentangled from capitalist logics of accumulation, labourer alienation, and maintenance of the body of the labourer. Additionally, this paradigm pervades other nominally caring systems, including most pertinently education and our interpersonal relationships as we accept and internalize logics of surveillance. This paper first puts forth a theoretical framing of how surveillance as care works alienate us from ourselves, situates this theoretical framing within Critical Disability Studies, Marxist and Surveillance Studies literature, and then turns to delve into how surveillance as care appears as a paradigm to surveil Mad and disabled students in secondary and post-secondary education. Surveillance of Mad and disabled students is discussed through two illustrative cases one which details how a private high school worked to use surveillance of students to define certain students it deemed it could not care for out of the student body and how this lead to lateral surveillance among Mad students, and another which details how a public university's use of surveillance alienated students from themselves through the use of student wellbeing data to avoid institutional liability and how students dissented to surveillance.

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Introduction

We are increasingly living in a form of the Foucauldian panopticon where what we do is increasingly watched, scraped, and profited off as our lives have become increasingly digitally mediated. However, this surveillance is not new. Rather, since the mid-19th century medical historians have considered Western hegemonic medicine to be operating within the paradigm of the 'normal body' where our bodies are conceptualized as statistical points and medical care is conceptualized as bringing those statistical points into alignment with an idealized norm. Examples of this paradigm range from blood tests to mental health questionnaires to less formalized digital personal health tracking. Additionally, much work has been done to point out how this paradigm has been utilized, since its inception, to enact settler-colonial, queerphobic, sanist, eugenicists, and White supremacist aims. This has led many disabled, Mad, 2SLGBTQ+, Black and Indigenous individuals to fear violence, surveillance, and oppression in medical care settings.

In this paper, I offer that the paradigm of the 'normal body' and the understanding of surveillance of the body as care that comes with it cannot be disentangled, much like medical systems as a whole cannot be disentangled, from the capitalist structures in which they operate. Surveillance of the body, as I will describe, alienates us from our bodies because as a part of surveillance capitalism it is based in a commodification of the body for work, much like Marx theorized that labourers become alienated from themselves once the object of their labour confronts them. Additionally, I offer that similar to how capitalism has prevaded our interpersonal interactions and self-valuation, surveillance pervades our interpersonal interactions and views of the self-outside of the realm of formalized medical care. I base this second theoretical offering in work in Surveillance Studies that has defined self and lateral surveillance.

I then ask if: (a) our bodies are conceptualized as data and healthcare is operating within a paradigm of surveillance of that data, (b) this surveillance is intrinsically tied with the alienation of the labourer under capitalism as our bodies become sites of surveillance capitalism, and (c) this surveillance pervades our relationships with each other and with institutions outside of the medical field, then how does surveillance as the predominant way of offering care get taken up by educational systems and how does this impact disabled and Mad students? I pose that educational systems: (1) construct imaginings of normative students that rhetorically position disabled and Mad students as legal liabilities, burdens and threats to the academy, (2) institutions then surveil their students and prospective students for signs of disability and Madness in order to enforce imaginings of the normative student, and (3) institutions know this surveillance is often not an accurate accounting of student wellbeing, however that does not particularly matter as it is utilized to avoid legal liability. However, Mad and disabled students are not idle in the face of this surveillance; I pose that disabled and Mad students both: (a) internalize these logics of surveillance to enact self and lateral surveillance to avoid being removed from the institution, and (b) enact dissent against these systems of surveillance once they are aware of them either through re-appropriating the apparatus of surveillance into one of complaint or giving the system un-usable data.

There has been work done at the intersection of Surveillance Studies and Critical Disability Studies previously. However, this work has often been deeply rooted in theorizing surveillance as a part of the experience of disability and madness more broadly (Saltes, 2013; Subramanium et al., 2025; Earle et al., 2009; Vaz and Bruno, 2003; Maclean, 2016). Often these inquiries how been focused solely on institutional surveillance – surveillance by state systems of disability benefit assessment, surveillance as a part of academic systems of accommodation and

systems of reporting students, and surveillance by the state in the process of immigration at ports of entry (Subramanium et. al., 2025; Earle et al., 2009; Vaz and Bruno, 2003; Maclean, 2016). While there have been some works, mainly works that focus on how disability rights movements claim legitimacy by counting who is disabled (Saltes, 2013), that discuss usage of medical or state surveillance apparatuses by disabled individuals, there have not been many works that blend this understanding of institutional surveillance with how individuals surveil each other in interpersonal dynamics. There have been works that allude to how surveillance apparatuses of capitalism or capitalist ableist logics of benefit rationing have led to a surveillance of who deemed to be more disabled in movement spaces (Nishida, 2022; Piepzna-Samarasinha, 2022; Spade, 2020), however these works often do not engage in looking at how this surveillance fits into the theoretical offerings of Surveillance Studies. Thus, while I pause to call this work a new or unique offering as it is based in and built upon disability and Mad experience that has been described by others, the novelty of this work comes in the blending of both an institutional ethnographic and autotheoretical exploration of how Madness and disability get surveilled by academic institutions, how this surveillance in academia is linked to histories of medical surveillance and eugenics, and how this surveillance seeps into our interpersonal relationships.

The first section of the paper introduces the autotheoretical and institutional ethnographic methodological approach used in this inquiry. This discussion of methods is followed by a brief discussion of my own positional background and how my lived experience informs the theoretical offerings of this paper and who my analysis is accountable to.

The next section of this paper outlines the current theoretical landscape. I outline how since the mid-19th century we have been in what medical historians would consider the paradigm of the ‘normal body’ where Adolphe Quetelet positioned an idealized normal body as being at the

statistical average of measurements, and then Sir Francis Galton moved this normalization from the statistical middle to one end of the statistical bell curve with anything outside of this ideal placed as abnormal and unhealthy. Next, I offer some examples of how this paradigm still shows up in medical settings through the quantification and datafication of bodies to compare against this normal in both physical and mental health settings. I discuss flaws with this system of datafication including a de-personalizing of the patient to the healthcare provider, an alienation of the patient from themselves and their own health data, and how comparing patient data against an idealized normal body continuously defines disabled, Mad, 2SLGBTQ+. Black, racialized and Indigenous individuals outside of the norm offered by the medical setting, pathologizes these individuals as unhealthy, and thus leads to medical violence, surveillance and further marginalization. This is followed by a discussion of Hegelian and Marxist theories of alienation with a discussion of how the alienation of individuals from themselves through the datafication of their bodies through healthcare systems has to be read in concert with the conceptualizations of alienation discussed by Hegel and Marx in the context of labour because of the role of healthcare in the maintenance of the body of the capitalist worker, and the role of healthcare within global systems of labour extraction. Additionally, I foreground how this alienation is taken up in pursuits of care outside of the formalized healthcare field with a focus on how educational systems view themselves as caring for students through assessments of student achievement and quantifications of student risk. Finally, I discuss how this all leads to the main theoretical offering of this paper – that academia views caring for students through the surveillance of students, how this surveillance is deeply tied to the idealization of the seemingly 'normal' non-Mad and non-disabled student, and how the alienation imposed on individuals

through this surveillance then leads to interpersonal surveillance and resistance to the surveillance system.

Finally, I explore this theoretical offering through two illustrative case examples, one a private college preparatory high school in the United States and their forced medical leave policy and the second a large public university in the American Midwest and systems of reporting on students through student Residence Life staff surveillance of students and how this surveillance was utilized when professors filed student of concern reports. In both of these illustrative examples I also note how students responded to this surveillance, through both self and lateral surveillance. In the latter example, I also document how students, when they were made aware of this more covert surveillance, were able to change structures of surveillance into structures of complaint against the university. Additionally, students purposefully gave surveillance systems non-usable data as a way of rhetorically saying to the system that they saw the system seeing.

Positional and Methods Background

Autotheory is described as "work that engages in thinking about the self, the body, and the particularities and peculiarities of one's lived experiences, as processed through or juxtaposed against theory – or as the basis for theoretical thinking" (Samuels, 2023, p. 203). While Samuels (2023) contends that there is no form of autotheory that is not inherently ill, disabled and crip, naming crip autotheory, as Samuels does, centers that "there is no body without the mind or mind without the body" (p. 204). The conceptualization of surveillance as care and that surveillance being utilized by our academic systems leads to engagement in self and interpersonal surveillance is wrought with my proverbial fingerprints and the particularities of my lived experience. This theoretical offering cannot be severed from my own lived

experiences as a queer and trans person surveilled as an American citizen under the pressing fascist transphobic milieu of the second Trump administration, it cannot be severed from my lived experience as a Pimicikamak Cree person who carries the generational trauma of forced sterilization and medical violence, and it comes from being a suicidal and Mad preteen in an era where there were increasing calls for students to alert educational apparatuses to each other's suspected suicidality.

Thus, I cannot explain to you how I come to this research without explaining who I am through my relations, both human and more-than-human, without visiting with you on the other side of a screen, or page, to show you who I am and the context that informs this inquiry.

I grew up a white-passing disconnected mixed-Pimicikamak Cree, British, Scottish, and Irish kid whose existence was created, marred and realized through the realities of settler-colonialism enacted by the Canadian government, the American government, and the British Crown. I am both the nicâpân of my nicâpân who escaped the horrors of the residential school system through immigration to the United States and the great-grandchild of Canadian Home Children who were trafficked from Britian, Scottland and Wales to serve as forces of labour and colonial expansion. I grew up in the fallout of multiple generations slipping into whiteness slowly, painfully and incompletely. I am now on a lifelong journey of reconnecting as assimilation did not save my granny/nôhkom and will not save me.

I am the multiply disabled child of a multi-generationally ill and disabled family. Because of legacies of medical violence, forced sterilization and eugenics, I did not learn about disability pride and culture until my early teens. I grew up in education environments that either labelled me as deficient or told me I did not belong as my autistic, dyslexic, chronically ill, pain-filled, Mad, limping self. I decided to claim disability to spite them. This spite grew into identity.

I am a transgender and queer man who came into an understanding of my transness and queerness during the first Trump presidency whilst living in the United States. I came out to myself and to others in the midst of a transgender Necrocene, amidst what has been deemed a genocide against transgender Americans, and amidst the undoing of transgender lives by a violent conservative politic that is increasingly taking more.

I tell you who I am and give you glimpses of who my relations are not as a spelling out of pain. Rather, I lay this out to allow you to glimpse, if only briefly, the context I exist in, the proverbial sauce in which my ideas marinate. Additionally, my ethic as a researcher is grounded in ᐊᐧᐦᑯᑐᐧᐃᓐ wahkôtowin, the belief that all beings are related and that we must build good relations with and be accountable to the land, plants, animals, kin, spiritual beings we encounter in this life, those who will come before us and those who will come after (University of Alberta, n.d.; Cardinal, 2007; Campbell, 2005). Not if but when I get things wrong it is my relations who hold me to account.

These relations do not just hold me to account but also ground my autotheoretical work. The self has its limits, and I am deeply wary of my hands flattening the cacophony of the lives of others into my singular voice, especially as academia is wrought with histories and presents that enact epistemic violence by applying totalizing lenses to community experience. The choice to anonymize the institutions and the individuals that lived with me through these institutions as detailed in this Major Research Paper was not an easy one, especially as my experience, and thus my theoretical offerings, was/is shaped by being in community with and informed by these individuals. However, I have chosen to anonymize both the institutions and the names of the individuals for two primary reasons. Firstly, as I will detail in the second illustrative case, some of the lived experience that is at the heart of this theoretical offering comes from my time

working as a student Residence Life employee for a large public university in the Midwest of the United States. In this job I was the first point of contact of 30 to 50 students each year and was giving reporting requirements as a part of my position. In this case the information of the students who I worked with is protected by the Family Educational Rights and Privacy Act, also known as FERPA (Family Educational Rights and Privacy Act, Pub.L. 93–380). The Family Educational Rights and Privacy Act prohibits me from disclosing whether an individual has attended a university, whether a student lives or has lived in a certain residence hall, and the content of any conversation had between me and that student in my role as a student Residence Life worker (Family Educational Rights and Privacy Act, Pub.L. 93–380). Thus while I will be discussing examples of how students dealt with and were impacted by university surveillance systems that were operationalized through the work of Residence Life and my work as a student Residence Life worker, all identifying information about the students, which residence hall we lived in, or which university this took place at was removed, with the exception of information that is helpful for the broad context of the community I am discussing – for instance the fact the university was in the United States, the broad demographics of the students I worked with across all three years of being on the job, and the particularity that the community was an LGBQT+ inclusive living learning community. Secondly, while the first exemplary case does not include individuals whose data is protected by FERPA, because they were my peers and friends in high school and thus I was not in a position of authority with FERPA protected information, I have chosen to anonymize the name of the institution we attended, referring to it as a private college preparatory high school in New England, because this institution has a vast and influential alumni network who often tend to be very protective of the image of the institution. Because of this, after conversations with my peers whose high school experience is closely entwined with

mine, I made the choice to anonymize the name of the school to not unnecessarily limit any future connections with the alumni network these friends might choose to pursue which may be limited if they were linked more directly to this project. This anonymization was approved in the context of these methods by the York University Research Ethics Board delegate for the Department of Critical Disability Studies, in line with ethics processes for Major Research Papers.

However, I write this not just for myself and rather I write in hope that this theory has resonance outside the particularities of my lived experience. The limited vantage point of the self can have its limits and can lead to a flattening of the self to fit the theory. To resist this flattening, I braid in institutional ethnography. My experiences of the institutional systems documented in the two illustrative examples are not unique, and I simultaneously do not have a full experience of all aspects of these systems. Institutional ethnography grounds this work in an understanding of the policies of forced medical leave in case example one and of student of concern reporting in case example two, how these policies are written and communicated to institutional staff respectively. This grounding offers the understanding that these experiences are systemic outcomes instead of unique experiences. The two institutions provided as illustrative examples in this paper are not provided for any particular uniqueness – rather they are no more unique than any hospital is as an example of care as surveillance in the hospital setting. Institutional ethnography works to also document how these systems are not unique and are actually, to the contrary, rather quite standard across private high schools and public universities in America, respectively.

Theoretical Background

Our Bodies as Data

Medical historians widely consider Western hegemonic medicine to be operating within a paradigm of the 'normal body' (Caponi, 2011; Crawley, 1993; Tafreshi; 2022). Within this paradigm there is the positioning of the statistically average normal body as the healthy ideal (Caponi, 2011; Crawley, 1993; Tafreshi, 2022). Bodies that fall outside of this statistical average are then deemed to be abnormal and unhealthy (Caponi, 2011; Crawley, 1993; Tafreshi, 2022). This statistical average is found through the quantification of bodies by functions of medical care (Caponi, 2011; Crawley, 1993; Tafreshi, 2022).

While the concept of comparing our bodies to an idealized norm might seem so natural to us as to have always existed, as pointed out by Leonard Davis the words 'normal,' 'normality,' 'norm,' 'average,' and 'abnormal' only entered the English language around 1840, previously the word 'norm' had been used in carpentry to mean perpendicular (1995, p. 24). The paradigm of the 'normal body' dates back to the mid-19th century writings of Belgian statistician Adolphe Quetelet (Caponi, 2011; Crawley, 1993; Tafreshi, 2022; Pence, 2024; Davis, 1995). Quetelet, in his 1835 treatise *Sur l'homme et let développement de ses facultés, ou Essai de physique sociale, translated to either Treatise on Man* or *On Man and the Development of his Faculties, or Essay on Social Physics*, turned his investigation into the statistical average of the height and weight of men in Belgium into his conceptualization of *l'homme moyen* — translated as the average man — and the Body Mass Index (Caponi, 2011; Crawley, 1993; Pence, 2024; Tafreshi, 2022; Grue & Heiberg, 2006; Beirne, 1987). This idealization of normalcy for Quetelet was not just a physical average but was also moralized (Davis, 1995; Grue & Heiberg, 2006; Beirne, 1987). Quetelet believed in a social physics where if bodies were to be brought into conformity with the average

then there would be moral conformity in society (Davis, 1995). This moralization of health both built upon and was markedly different from prevailing theories of contagion and illness of the time – miasma theory where foul smells and "bad air" were deemed to be the source of contagion, fomite theory where otherwise harmless substances were believed to contain the "seeds" of disease, and zymotic theory where otherwise harmless substances when consumed could cause fermentation in the body to cause illness (Jacobson, 2024). Unlike these theories, the work of Quetelet placed the root of health in the body, as a deviation from the normal body[1].

[1] The statistical approach of Quetelet to health was taken up to inform other theories of illness, including zymotic theory. The zymotic theory of disease was promoted in the mid-19th-century by Florence Nightingale and Elizabeth Blackwell, both of whom were early proponents of a professionalization of nursing in England and in the United States respectively (Jacobson, 2024). The zymotic theory of disease places illness as caused by the fermentation of pollutants in the body (Jacobson, 2024). The zymotic theory was particularly in line with Nightingale and Blackwell's aims of making space for women within medical practice because it re-centered illness as being related to the cleanliness of the home (Jacobson, 2024). This recentering of illness as being based in the domestic sphere situated women as on the front lines of medical knowledge and combatting of illness as starting in the early 17th century in England women had been disenfranchised out of agricultural jobs through a closing of the commons and disenfranchisement of poor peasantry by the privatization of public lands by lords (Jacobson, 2024). The statistical framing of health offered by Quetelet, was taken up by Nightingale (who was a close collaborator of Quetelet) to prove the value of nursing by showing how sanitation can decrease disease and improve disease outcome. Whilst serving as administrator of nurses

The Body Mass Index (BMI) went on to be taken up by Sir Francis Galton, Karl Pearson, and R.A. Fisher, all of whom were both prominent European statisticians and key figures in the eugenics movement (Davis, 1995; Caponi, 2011; Crawley, 1993; Pence, 2024). Statistics was key to the adoption and aims of the eugenics movement because it provides the idea that a population can be brought into line with a norm and gives a justification to the dividing of a population between normal and abnormal, however arbitrary and eugenically derived the line between normal and abnormal may be (Davis, 1995). Galton however added 'error theory' to the work of Quetelet (Davis, 1995). Error theory originated as a technique used by astronomers to find the location of a star by taking into account the large variety of sites in the sky where the star was claimed to be sighted and then plotting these locations into a bell curve (Davis, 1995). Astronomers held that the most correct location of the star would be the location with the most sightings, the middle of the bell curve – this curve was originally called the 'error curve' and its name was changed by Galton to 'the normal distribution curve' (Davis, 1995). This change in name is important because rather than the ends of the curve being errors, Galton proposed that when looking at humans the extremes of the curve are important and the middle must be seen as

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during the Crimean War, Nightingale collected statistical data on how many and which soldiers entered and left the hospital camp, what injuries these soldiers sustained, whether these injuries were caused by combat wounds or diseases related to sanitation in the camp, and whether the soldiers died in the military camp (Jacobson, 2024). This data was presented as a polar area diagram, known also as a Nightingale rose diagram, which Nightengale pioneered to show that death during war could be attributed to 'zymotic diseases' and thus greatly decreased through the use of nurses (Jacobson, 2024; Nightingale, 2013).

a mediocre middle (Davis, 1995). For example, if you were to graph the foot length of every Canadian, Quetelet would say that the average foot length would be the norm so therefore the most desirable, whereas Galton would say that the average foot length is the mediocre middle and rather the highest quartile of the curve is the most desirable, followed by the second highest quartile and so on.

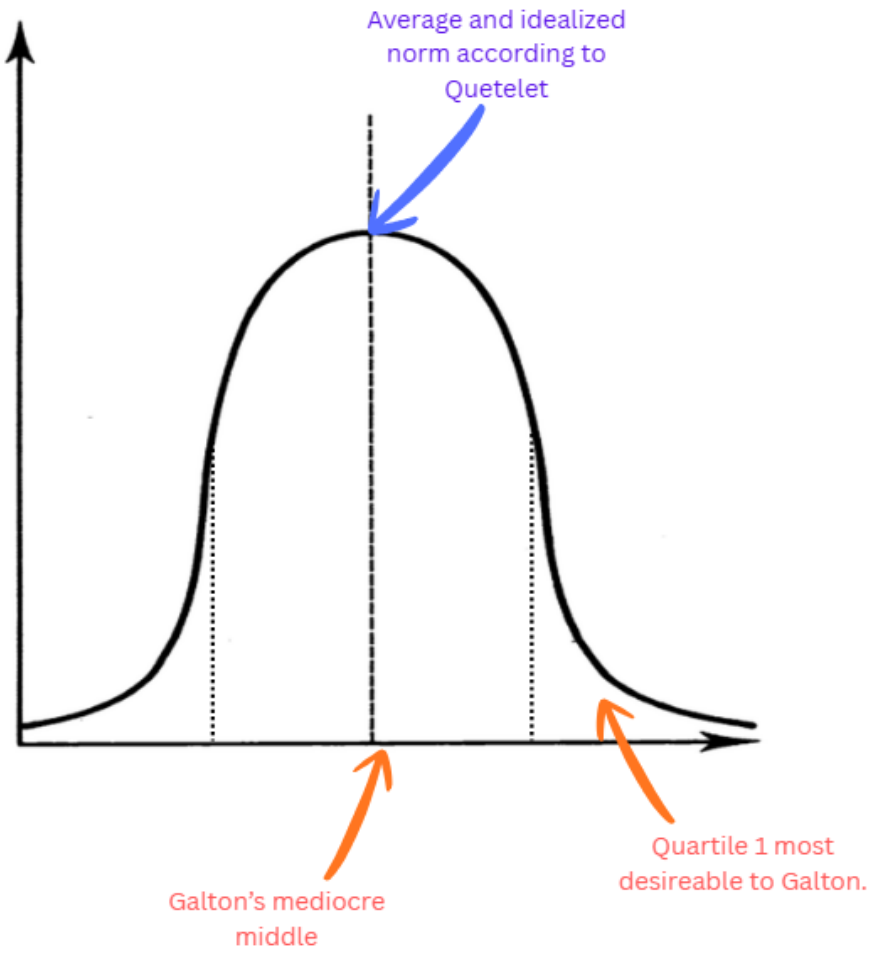


Figure 1: A visual representation on a bell curve of the difference between Galton's conception of the mediocre middle and idealizing in ranked quartiles and Quetelet's idealization of the norm.

Galton's reframing of the normal distribution curve is still prominent in the ranking of medical measures, along with IQ and academic aptitude tests by quartile (Davis, 1995). For instance, parents of infants often get told their infant's growth is within a certain percentile with that percentile calculated by comparing their weight and length to that of other infants of the same age and sex with 50th percentile being deemed average. Additionally, when students in the United States take the Scholastic Assessment Test, better known as the SAT, to get into university, the score they receive is a number between 400 and 1600 and a percentile ranging from 1 to 99, the percentile compares the student with everyone else who had taken the test that year. For instance, a percentile score of 73 would mean the tester did better than 73% of students who took the test that year. While we now know that the far end of the bell curve is not always in line with eugenicist medical ideals, for instance having long limbs and being tall is a sign of Marfan's syndrome, the idea of comparing the body to an idealized statistical point and working to bring the body into conformity with that point is still widely practiced.

The paradigm of the 'normal body' and the quantifiable comparison of bodies and bodily functions is still rampant in our medical system. One of the clearest examples of this is how data from blood tests and mental health questionnaires are compared to a 'normal' or 'healthy' range in electronic medical systems. However, as I will detail, this data is held against a normal in ways that separate us from our body, and define an oppressive normal.



Figure 2: A screen shot of a creatinine blood test result of 0.72 mg/dL with a labeled 'normal range' of 0.70-1.50 mg/dL.

Figure 2 shows my own creatinine levels taken during a comprehensive metabolic panel. As someone with Hashimoto's thyroiditis I have a comprehensive metabolic panel done every six months to help determine my thyroid functioning, and yet I would not be able to tell you what the difference between 0.69 and a 0.72 creatinine level feels like in my body. Rather, I know 0.72 is a number my doctors are happy with, that doesn't lead to more follow-up visits or testing. It is a number deemed normal and therefore healthy. It **makes me** into a number deemed normal and healthy. This datafication of my body helps depersonalize me to my providers, rather than being a human I become a checkbox, a bi-annual check to see if the number is within the normal zone. It is for this reason that many chronically ill people, including myself, have run into situations where we are in pain, fatigued, or experiencing other manner of severe medical symptoms but our tests are within the normal range so we are told by doctors we are fine. Well, in the best case we are told we are fine. In the worst case for many individuals read as femme[2] the deviance of insisting on medical care regardless of "normal" medical test results is labeled as

[2] I utilize the phrasing of "individuals read as femme" here to encompass how misogyny within medical settings is enacted by medical providers upon individuals who are deemed by medical providers upon first glance to be female or female presenting, regardless of the gender identity or sex assigned at birth. Additionally, I also use the phrasing to note how regardless of gender presentation or gender identity medical providers' misogyny/antitransmasculinity in medical settings is often experienced by people who have a note on the medical chart that they were assigned female at birth.

histrionics or anxiety. For individuals who are racialized and poor, insisting on medical care after receiving "normal" medical test results gets framed by providers as drug-seeking or malingering. In all of these cases, however, the experience of the patient in their body gets depersonalized into a test result or number. When medical professionals are made to confront the falseness of their interpretation of number, the response of the patient is often what gets pathologized and deemed as deviate instead of medical care for the symptoms or an exploration of why a medical test result might not match patient experience.

This separation of patients from the quantified forms of their own body functioning also can occur through this data being compared to a normal that centers White, upper class, cishetero non-disabled bodies.

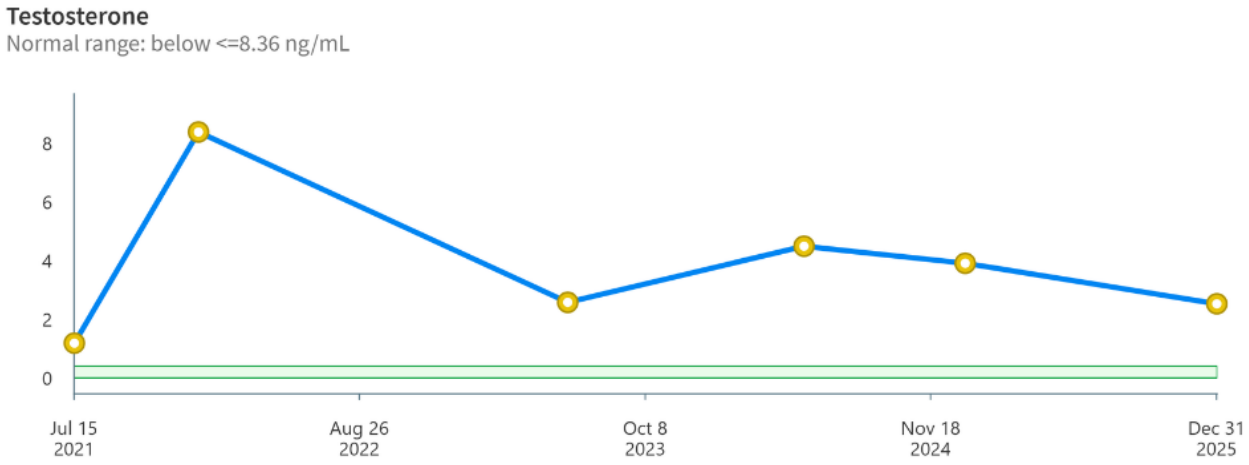


Figure 3: A graph that compares testosterone levels over time with six tests between July 15 2021 and December 31, 2025. All test results are indicated as being outside the normal range.

Figure 3 shows my testosterone levels over time between July 15, 2021 and December 31, 2025. I am a transgender man who began taking testosterone on April 15, 2021. As noted in Figure 3, every result is noted as being outside a "normal" range. This is because these test

results, as someone who was assigned female at birth[3], are assessed against the norm of testosterone levels for cisgender women. These results consistently remind my providers and me

[3] Assigned Gender At Birth (AGAB) is a term that comes from intersex community and community activism spaces and has been taken up by transgender movement spaces, their cisgender allies, and Trans Exclusionary Radical Feminist (TERF) spaces in ways that often serve to reify sex and gender binaries and in ways that do not take into account the violence of medical gender assignment (personal communication in intersex community spaces, 2026). For instance, online discussion about Assigned Female at Birth (AFAB) Autism was originally adopted to move away from the erasure of trans men, non-binary and trans-masculine individuals by saying 'girl autism' or 'female autism' however AFAB Autism and the rhetoric around it has the effect of (1) insisting that there is a sexed difference in autism presentation that reifies a binaristic view of sex, (2) AFAB is used as a stand in for "anyone who was raised with the social expectations of girlhood" with an assumption of White western often protestant Christian expectations of girls and assumptions that everyone who is assigned female at birth would experience girlhood – something that is becoming less and less true as trans masculine kids of certain socio-economic statuses are getting access to puberty blockers earlier and we see a rise in gender expansive/creative parenting practices, and (3) to exclude trans women from experiences of misogyny that could lead to differences in presentation of masking or other autistic traits (personal communication in intersex community spaces, 2026). Additionally, using Assigned Female at Birth as a stand in for "anyone who experienced girlhood" takes away the violence of forced gender assignment. Coerced Assigned Gender at Birth (CAGAB) and Designated Gender at Birth (DGAB) have been used since the 1990s in intersex community spaces to try to reaffirm

that my transitioning is transgressing an ideal of normal that defines the physiology of cisgender people within that norm and transgender people as outside of it. We see this normal also being defined as "healthy" and transness being pathologized: from the inclusion of gender dysphoria in the Diagnostic and Statistical Manual to how transgender individuals wanting gender affirming surgeries in many areas are required to get signed letters from mental health providers that indicate the necessity of these surgeries (Dewey & Gesbeck, 2017). This is just one of many examples of how the idealization of normal as healthy has been taken up to enact settler-colonial, queerphobic, sanist, eugenicist, classist, and White supremacist aims. This conflation of normal and healthy leads individuals who are defined outside of the norm, including disabled, Mad, 2SLGBTQ+, Black, racialized, and Indigenous individuals to fear violence, surveillance and oppression from medical care settings, as our healthcare providers continue to view us as abnormal and thus unhealthy.

This conflation of normal and healthy that separates patients from the embodied feelings of their own data, and that centers a normal informed by settler-colonial, queerphobic, sanist, eugenicist, classist, and White supremacist ideals, is not just limited to the realm of physical health but is also seen in how mental illness gets quantified to determine severity.

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the violence that happens in medical gender assignment. However, these terms are often not recognized or well understood outside of intersex community because of the persistent co-optation and popularization of Assigned Gender at Birth (personal communication in intersex community spaces, 2026).

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Figure 4: A Patient Health Questionnaire – 9 (PHQ-9) form commonly used in the screening and assessment of major depression.

The Patient Health Questionnaire – 9 (PHQ-9) is a form commonly used in the screening and assessment of major depression. It originally was used within the confines of psychiatrist and psychologist offices but has gained wider use in primary care offices as a screening tool. The questionnaire has patients respond to prompts regarding how much and how often they have been bothered by a litany of experiences with the responses ranging from 0 / Not at all to 3 / Nearly Everyday. The tool seeks to quantify the feeling of being depressed, but this quantification can often separate individuals more from the emotion of being depressed as they seek to try to fit their experiences into quantification. A 2025 study from Hylnsson et al. entitled *Why are we still using the PHQ-9? A Historical Review and Psychometric Evaluation of Measurement Invariance* found that not all respondents use the PHQ-9 in the same manner, and that changes in PHQ-9 scores over treatment weeks may reflect shifts in how participants interact with the questionnaire rather than changes in their symptoms (Hylnsson et al., 2025). The scale is less reflective of an individual's symptoms and rather is reflective of patients trying to quantify their experience against an implication from the scale of what is normal. For instance, as someone who has had to fill out the PHQ-9 I find the classification of "more than half" to be confounding. For instance, if I was feeling down, depressed or hopeless 14 days of the month, would that be more than half or not? The PHQ-9 also assumes patients are living within a social environment that is not depressing, there is no place on the form to check if you are watching the horrors of multiple genocides unfold on your screen or if you are living through the rise of an authoritarian government. The questionnaire seems to reflect a normative standard of mentally healthy that doesn't just not line up with current lived reality but asks patients to be unfeeling and separated from their current horrific experiences.

We Become Separated From Ourselves

This practice of conceptualizing our bodies as data doesn't just depersonalize us to medical providers it also separates us from ourselves. This feeling of being separated from the self has been a place of philosophical inquiry within the context of consciousness and what it means to be aware of the entity of the self. George Wilhelm Friedrich Hegel developed his theory of alienation in response to notions from Kant and Fichte that consciousness requires a subject or object and requires a social process (Debnath, 2020). Hegel conceptualized that we are all born alienated, or separated, from ourselves and that we bridge this gap to become unalienated through taking up the role of labourer (Debnath, 2020). Acting as a labourer allows us to become unalienated through imposing our will on another being through making that being into an object (Debnath, 2020). This objectification reasserts our position as a subject (Debnath, 2020). Hegel then holds we can become alienated once again when the product of our labour becomes commodified since commodification makes the object something we can no longer express our will onto (Debnath, 2020). I find Hegel's explanation of alienation to be operating from the flawed assumption that the position of subject can only exist within opposition to the position of object. For instance, Hegel's conceptualization of alienation would imply that individuals who either cannot or do not engage in labour are never unalienated and thus can never be fully themselves.

Karl Marx contends that Hegel's idea of alienation does not properly look at the relations between individuals as expressed through labour, and reproduces the capitalist assumption that labour leads us to being unalienated, further reinforcing capitalist ideologies of labour (2015). Marx offers the theorization that we are born unalienated and become alienated through labour (Marx, 2015). Marx contends that as the value placed on the products of one's labour increases or the amount of labour an individual takes on increases, the more an individual becomes

alienated from both the product of their own labour and from themselves outside of the context of labour, as the product of their labour comes to confront them as an alien force(2015). Additionally, Marx theorizes alienation as emerging from to capitalist social relations (2015). Alienation is intrinsic to capitalism for Marx, in part, because individuals are coerced into labour and production within capitalist systems in order to sustain life (2015).

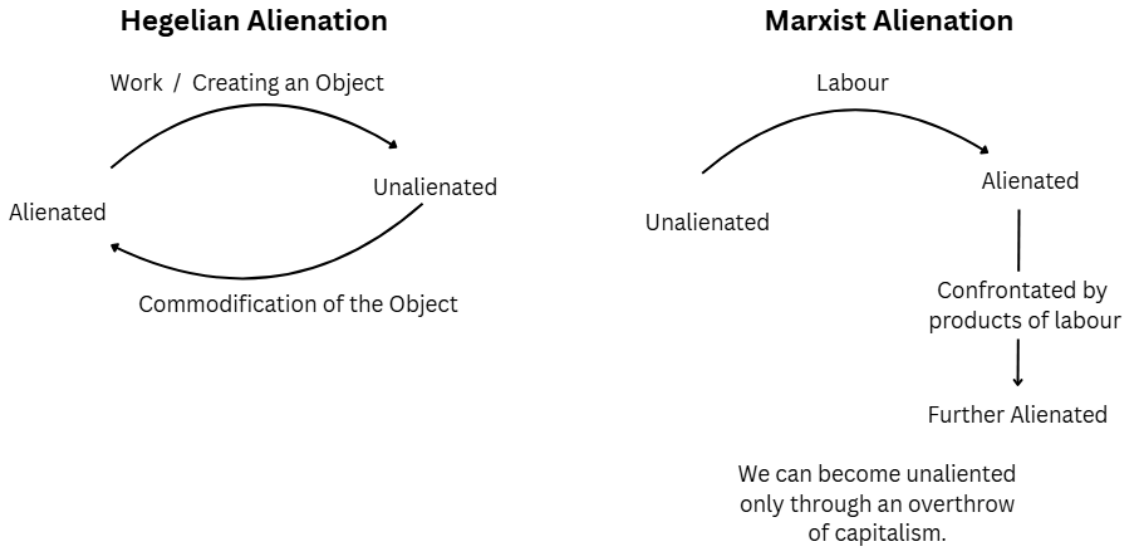


Figure 5: A visual representation of the differences between Hegelian and Marxist Alienation detailed in the previous section.

We Become Separated from Our Bodies

Marx notes that alienation does not just impact an individual's valuation of their self, but that labour also alienates individuals from other people when human relations become mediated through market value, and that labour alienates us from being human through dehumanizing and commodifying us (2015). Other scholars have discussed how capitalism impacts our interpersonal relationships. Notably, Dean Spade (2020) in *Mutual Aid: building solidarity*

during this crisis (and the next) discusses how capitalist logics and demands have pervaded our interpersonal interactions around care giving and receiving even in nominally anti-capitalist social movements. While Spade (2020) does not use the term alienation, Spade's conceptualization of capitalist logics and demands, where individuals who proclaim to be anti-capitalist inadvertently end up reinforcing capitalist valuations of others, feels like a symptom of alienation where when individuals become alienated from others and themselves; and relationships become mediated by markets. Then this market mediation is what Spade is describing as the imposition of capitalist logics and demands onto our interpersonal relationships. Spade (2020) argues the imposition of capitalist logics and demands can show up as imposing capitalist valuations of deservingness on ourselves and others; confusing urgency of a task with the importance of that task with urgency of the tasks set not by the individual but by larger capitalist systems– much as how systems of bells and alarms were introduced into the public sphere during the industrial revolution as the pace of labour moved from being set from the individual to being set by the corporation (Thompson, 1967); centering work over relationality; and neglecting rest and comfort for the sake of increased work. Spade (2020) and Marx (2015) both come to the conclusion that through challenging, decentering and ultimately replacing capitalism and its logics we become more unalienated from both ourselves and those we are in relationship with. Spade (2020) envisions this decentering of capitalism happening through mutual aid as a system that works beyond the auspices of capitalism to provide care for all people from all people in ways current charity models, nonprofits, and governmental agencies fail to do.

However, there have been challenges in how mutual aid gets put into practice. Leah Lakshmi Piepzna-Samarasinha (2022) in *The Future is Disabled: Prophecies, Love Notes and*

Mourning Songs, notes that when particular focus is not given to looking at how capitalism places specific labour expectations on racialized and feminized individuals often then we risk repeating capitalist structures within mutual aid and interdependent structures where femme individuals of colour have their labour disproportionately exploited. Piepzna-Samarasinha (2022) also brings in a crip-of-colour critique through noting that in structures of mutual aid and interdependence often there is a singular non-disabled labouring productive organizer. This idea of the non-disabled organizer often leads to the exclusion of cripped interdependencies that have been created by disabled people and can lead to the relegation of disabled individuals solely to the role of receivers of mutual aid (Piepzna-Samarasinha, 2022). These challenges also get noted by Akemi Nishida in *Just Care: Messy Entanglements of Disability, Dependency, and Desire*. Nishida (2022) notes within interdependent or mutual-aid based care webs challenges arise when individuals who are deemed to be 'less disabled' often take on disproportionate amounts of care work, often leading to lateral surveillance around the valuation of who is disabled and who is not.

Quantification and Alienation As Care

We have established that our bodies become quantified through datafication; that this turning of our bodies into data both works to dehumanize us to medical providers and alienate us from ourselves; that this datafication centers the normalized ideal of a cishetero White wealthy non-disabled person in ways that dovetail with larger histories of marginalizing bodies through pathologization; and that this alienation is similar to capitalist alienation as framed by Karl Marx.

However, this alienation is not just similar to capitalist alienation, it is part of capitalist alienation, since under capitalism we cannot conceptualize of our medical system as outside of

the auspices of the capitalist state and we cannot conceptualize of care as solely happening within the control of the medical system.

The Medical System as Part of the Capitalist State

While the connection between our medical care and the state is clearer in countries that have government run single-payer healthcare systems, for instance what is covered under the Ontario Health Insurance Plan (OHIP) being dictated by the Ontario provincial government, it is also strikingly clear in countries that on face-value state to be moving toward or having a privatized healthcare system, for instance the creation of Make America Healthy Again (MAHA) under the political movement Make America Great Again and how Secretary of Department of Health Services, Robert F. Kennedy Jr. has used his position to make claims ranging from asserting a linkage between acetaminophen and autism to supporting claims from Secretary of Agriculture Brooke Rollins that Americans can maintain a healthy diet for as little as $3 USD a meal as long as that meal includes “a piece of chicken, a piece of broccoli, you know, a corn tortilla and one other thing” a claim that is believed to place blame for increasing food costs on American citizens as the average American household spending on food topped over $10,000 per year for the first time in 2024 (Weil, 2026; Yandell, 2025).

Additionally, we know that the state plays a huge role in provisioning the supply of labourers that perform medical care. As noted by Akemi Nishida (2022) in *Just Care: Messy Entanglements of Disability, Dependency, and Desire* the United States government has used its history of colonial and lingering neocolonial control over the Philippines to aid in the extraction of labourers from the Philippines to serve as nurses and personal care workers in the United States. In particular, through shaping the educational system in the Philippines, the United States has made a system where nursing accreditation in the Philippines easily carries over to the

United States and allows for readily available pathways for individuals with nursing accreditation to move from the Philippines to the United States (Nishida, 2022). However, once Filipino labourers are in the United States they often work grueling and disabling care jobs and are not eligible, unless they gain citizenship, for systems that support disabled Americans like Social Security Disability Income and Medicaid (Nishida, 2022; Pyne, 2026).

While it is clear our medical system is shaped by the capitalist and colonial exploitation of labourers and bodies as an inherently political system, the medical paradigm of viewing the body as data and viewing the surveillance of that data as care is also a capitalist project. Soshana Zuboff coined the term surveillance capitalism in her 2015 article “Big Other: Surveillance Capitalism and the Prospects of an Information Civilization.” Zuboff (2015) frames that while previous capitalist ventures have worked to extract labour from the body, surveillance capitalism is a new logic of accumulation that views behaviours of the bodymind as raw material to be fed into algorithms in a computer mediated world to produce revenue through commodifying our everyday experiences. While previous forms of capitalism have worked to extract labour from the body, surveillance capitalism has turned the body itself, its behaviours and attributes into commodity. Under systems of surveillance capitalism, more than ever, we are placed as the commodity and surveillance is placed to both enact control on us as the commodity and to sell parts of us to others.

In the case of education, students need to be understood as commodities of education systems that are both surveilled for quality and sold in parts to other entities. For example, historians have argued that during the industrial revolution in the United States there was a movement of education from a private endeavor that took place in the home to a role taken on by the state in the form of public education (Thompson, 1967). This caused the point of education to

shift, often from an education that focused on the values of the community and possibly the learning of a trade to being focused on not just giving students the skills of a trade but getting them used to industrialized settings (Thompson, 1967). For example, some historians point out that industrialization created a need for public education in American cities because of population increase (Thompson, 1967). This influx of students led to education re-fashioning itself as training the next generation of factory workers not just in skills but in affect (Thompson, 1967). This need of shaping a good worker brought with it implementing the technology of the factory into the classroom like using bells to signal the beginning and end of the class period, the implementation of attendance policies, and late slips (Thompson, 1967). Education still takes on this attitude of needing to prepare students for the workforce. For instance, a brief scan of The Chronicle of Higher Education's Student Success section brings headlines like "An Earn-and-Learn Model Closes Skill Gaps," "How to Make Career Advising Work for First-Gen Students" and "Scaling Work Force Innovation: Key Strategies for Today's Career Education." While as academics we would love to think that students are taking our class for the sake of genuine intellectual curiosity we have to contend with the fact that many students take our classes for the simple requirement of earning a degree in an educational system, at least in the United States, where increasingly vast numbers of jobs that pay a living wage require some form of degree. And thus when tasked with the role of creating productive labourers our education systems surveil our students to deem whether they are productive.

Care through Surveillance as Happening Outside of the Medical System

As previously discussed, we are within a medical paradigm, innately informed by capitalism, where the body is seen as both a site of labour and a point of extraction of data and surveillance of the body is used not just to generate data on a supposed norm to compare other

bodies to but also as a site that needs to be brought into the norm to serve as a productive labourer. The surveillance of bringing bodies into that norm is often both alienating and framed as care. Till this point this care has been discussed, with the exception of brief overtures, as happening within the medical system. However, this framing of surveillance of the body against a supposed norm as a form of care is evident in other structures, for example carceral systems.

Example: Usage of Surveillance as by the Carceral System

Before the 18th century imprisonment was not widely used as a primary form of punishment, rather it was used as a temporary measure to serve a specific purpose, often holding someone to ensure a punishment or deciding of punishment could occur – for instance holding someone who was awaiting trial or holding an individual who was paying a debt (Chapman et al., 2014; Carrigan, 1994; Foucault, 1995; Guest, 1997; Rothman, 1971). Incarceration was not seen as rehabilitative or having a benefit to the inmate (Chapman et al., 2014). Incarceration only began to be seen as rehabilitative through the incarceration and confinement of disabled and poor people (Chapman et al., 2014). In particular, early almshouses claimed that through confinement they could provide individuals who were perceived as not productive labourers with care while also having inhumane and abusive conditions to dissuade those who could work from wanting to remain in almshouses to avoid work (Chapman et al., 2014). These conditions became more abusive and the use of incarceration ballooned as cities began to institute laws against vagrancy – for instance, by the late 1650s one out of every hundred Parisians was incarcerated (Chapman et al., 2014; Foucault, 1988). This mass incarceration both led to the creation of specialized confinement – differentiating between those confined for poverty, Madness, immigration, feeblemindedness, or legal delinquency – and the call for reforms to create more humane forms

of incarceration and to attempt to rehabilitate people so they could move out of carceral settings back into the general population (Chapman et al., 2014; Trent, 2014).

Michel Foucault in his 1975 book *Discipline and Punish: The Birth of the Prison*, details the carceral and surveillance logics of the panopticon, (Foucault, 1995) the panopticon was originated by philosopher and social theorist Jeremy Bentham in the 1780s as proposed human reform to the prison that dealt with the violence of prison guards by eliminating frequent interaction between prison guards and inmates (Foucault, 1995). Panopticons work through having cells that have two windows, one that allows light in from outside of the prison and one pointed toward the watch tower – this creates an effect where the guard is always backlit so prisoners can never discern whether a guard has their back turned to them and whether they are being surveilled at any given time (Foucault, 1995). Foucault posits that when prisoners are in the panopticon they assume they are always being watched by the guard, so they internalize the surveillance of the guard to surveil their own behavior. In the case of the panopticon there is an idealized inmate behaviour that prisoners then surveil their own behaviour to fit within.

Surveillance can expand from a self-surveillance to a surveillance of those close to us. Mark Andrejevic (2004) defines lateral surveillance in the paper "The Work of Watching One Another: Lateral Surveillance, Risk and Governance." Lateral surveillance was defined as surveillance that occurs between spouses, friends, relatives, co-organizers or other individuals within peer relationships (Andrejevic, 2004). Andrejevic (2004) frames lateral surveillance as simultaneously democratizing surveillance by enacting surveillance outside the power of the state but also as a mechanism states can use to offload surveillance duties onto the individual citizen. This offloading occurs when individuals internalize state surveillance apparatuses to

surveil their own behaviour and then turn those internalized norms of surveillance onto others (Andrejevic, 2004).

As will be discussed more thoroughly in the discussion of the two cases, often this quantification and surveillance happens but often without the same tools outside of the medical system. Educational systems position themselves as having a goal of caring for the student. While it can be argued that this care only extends to the point of either shaping the student into a productive labourer or ensuring that the student is well enough to pay tuition the next semester, this is still a form of care. However, educational systems don't use the same tools of quantification as the formalized medical setting, often instead of blood test results and psychological questionnaires they depend on grade-point-averages, student wellness reports, and a more covert creeping system of surveillance. Academia viewing wellness through surveillance is not a new theoretical offering within Critical Disability Studies. Rather, we know that disabled and Mad people in the academy, regardless of position as undergraduate students, graduate students, or professors, experience surveillance similarly to how disabled and Mad bodies are surveilled by the state for assessments of productivity more broadly (Price, 2011; Price, 2024; Saltes, 2013; Subramanium et. al., 2025; Earle et al., 2009; Vaz and Bruno, 2003; Maclean, 2016). Self-surveillance occurs when individuals internalize these logics of surveillance into a surveillance of their own behaviour, and lateral surveillance occurs when they turn this internalized surveillance into the surveillance of others.

Illustrative Case #1

From 2017 to 2021, approximately ages fourteen to seventeen, I attended a private college preparatory school in New England, on the east coast of the United States. This particular

school was known for being very prestigious, often ranking within the top five private high schools in the United States, having an acceptance rate of under twenty percent, and commonly placing upwards of ten percent of each graduating class at Ivy League universities. The school was also expensive, students who were not offered a need-based scholarship were expected to pay between $54,000 and $70,000 USD per year depending on whether they were boarding or commuting students. During my first three years I was a commuting student on nearly full scholarship before transferring to being a boarding student in my final year.

In this illustrative case, I will discuss how within this institutional setting disabled and Mad students were defined outside of the normal imagining of a student at this institution, and how this imagination of the normal student was maintained through systems of surveilling and systematically pushing students off of campus who were deemed to be unable to uphold the role of the "otherwise qualified" disabled student. I discuss, in turn, how in the face of institutional surveillance aimed at removing certain students from the institution, students engaged in lateral surveillance and self-surveillance in order to continue to perform the role of the normative student.

Defining Disabled and Mad Students outside of the Norm

Because of a combination of the lax educational accreditation standards in the state where the school was located, the fact that most of the buildings at the school were designated as historic, the school not receiving any federal money, and because of the school's large endowment of over 1 billion USD and large legal team, the school is effectively not required to abide by the legal requirements of either the Americans with Disabilities Act or the Individuals with Disabilities Education Act (personal communication between author and Coordinator of Academic Support at the school, 2019). This allows the school to both explicitly and implicitly

define disabled and Mad students as outside of the envisioning of the normative student. This defining of disabled and Mad students outside of the norm is clearest in admissions procedures and rhetoric around accessibility and accommodations in the student handbook.

Prior to the 2017-2018 academic year, the school had explicit wording in the student handbook that denoted that disabled students may not be a correct fit for the institution and that the institution reserved the right to include this bias in admissions decisions. This bias was felt starting in admission interviews. In both my admissions interview and the parental interview attended by my mother, we were asked to ensure the admissions officer that my dyslexia and other disabilities would not impact my experience as a student, or ability to participate in student life without accommodations (personal correspondence with Heidi Lockwood, 2017). While it is not explicitly noted, as a student I commonly heard that even after the removal of the wording from the student handbook that admissions officers would still ask parents during the parent interview to justify that the student would be a good fit despite their disability (personal correspondence with members of the school's disabled student union, 2019).

Even despite there no longer being official wording in the student handbook that denotes that the school reserved the right to enact bias against disabled students in admissions, wording in the 2025-2026 Academic Year student handbook still clearly denotes who the school perceives as deserving, or as it is termed "otherwise qualified" disabled students. At the beginning of the section of the 2025-2026 Academic Year version of the student handbook entitled "Disability Accommodations Policy," there is a note that "a disability may include a mental or physical impairment that substantially limits one or more major life activities" and that "disabilities may include, but are not limited to, mobility and other orthopedic impairments, sensory impairments, psychological disorders, chronic health impairments, and learning disabilities" (Institution's

Student Handbook, 2025). However, later in the "Disability Accommodations Policy" there is an outline of guidelines for disability documentation students will need to submit to obtain disability accommodations, these guidelines rhetorically lay out the type of disabilities the school expects students will experience and thus will need documentation to obtain accommodations for. These guidelines start as follows:

- "Documentation must be current.
    - For learning disabilities or ADHD, evaluations must be less than two years old.
    - For psychiatric disabilities, documentation must be current within one month and the Academy may require updated documentation at the start of each term or as otherwise needed.
    - For temporary medical conditions (concussion, orthopedic injury, mononucleosis, etc.), documentation must be provided upon a student's return to campus and must include both a start and end date for requested accommodations. If any changes or extensions to the accommodations plan are requested, updated documentation must be provided.
    - Updated documentation should be provided if any changes to the accommodations plan are requested or needed."

In addition to assuming that students were wealthy enough to receive evaluations, especially as many insurance companies in the United States will either not cover certain neuropsychological evaluations or only cover the initial assessment [4], only a small portion of

[4] A September 2020 student submission to an Instagram account that took the task of detailing the experiences of disabled students at the school noted that while a student scored within the

individuals with disabilities are imagined in these guidelines as potential students who may need accommodations. Most glaringly, while there is a note of documentation for temporary medical conditions, there is no note of guidelines for documenting permanent physical disabilities, chronic illnesses, mobility limiting conditions, visual disabilities including blindness, d/Deafness, speech and language disabilities, or neurological disabilities. Students with these conditions are rhetorically excluded from the imagination of students at the school.

This rhetoric also impacts attitudes. During my time as a student the school did not employ any staff members who had a specialization or accreditation in applications of the Americans with Disabilities Act, Individuals with Disabilities Education Act, or specialization or accreditation in screening of disabled students, working with disabled students, creating accommodations plans or providing accommodations, knowledge of assistive technology, organization of interpreting, captioning, or orientation and mobility services[5]. Rather, the staff member employed to oversee accommodations as the Coordinator of Academic Support had a

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range expected for someone who has ADHD on both the Comprehensive Executive Function Inventory and the Connor's Scale which is used to measure ADHD, the student was required to have a full neuropsychological evaluation, that would have a four month waitlist and require the student to pay $4,000 USD out of pocket.

[5] This list of desirable skills was pulled in part from my knowledge of Access Consult job postings and in part from this particular job description for an Accessibility Consultant in Student Development Services from Nipissing University with changes made to make it relevant to the United States context: www.nipissingu.ca/sites/default/files/2023-06/Accessibility%20Consultant.pdf

background in classroom management with a focus on study skills and a generalized M.Ed. (interpersonal communication between Coordinator of Academic Support and author, 2019). This led to approaches taken that did not meet the needs of students, including the forcible placement of students with conditions that impact executive dysfunction into remedial 'study skills' classes taught by the Coordinator of Academic Support where they were told their ADHD would get better if they 'just used a planner' (interpersonal communication between author and members of disabled student union, 2019). Additionally, this led to a shocking lack of accommodations for me as a student with dyslexia – despite the school having a $1.65 billion USD endowment with an annual distribution limit of $75 million USD which averages to $62,500 USD per student per year (publication in school's bulletin, 2026) – I was never offered access to screen reading technology, which I came to know of only after graduation, is a commonly provided accommodation for students with dyslexia and was provided to me by both my undergraduate and graduate institutions[6]. In summation, previous rules around who was deemed the 'right fit' for the school and the ability to discriminate on the basis of disability in admissions decisions and current rhetoric around who is imagined to need access to the institution both work to define disabled and Mad students outside of who is considered a normative or ideal student at this

[6] It is of note that my undergraduate institution had an endowment distribution of $10,976 USD per student per year, according to a 2025 Endowment report of the amount of funds transferred out of the endowment, and according to a 2023 Annual Investment Report my graduate institution had an endowment distribution of $302 CAD per student in the 2022-2023 academic year.

institution. However, students were not just defined outside of the normal during admissions decisions but were surveilled to ensure normalcy after admission.

Medical Leave Policy – "*I need you to promise"*

"I need some help."

"With what?"

"Well I am not doing great emotionally. But I need you to promise that you won't report me to counseling services or anyone on campus."

"Alright. What's going on? I'm not going to report you if you don't want me to."

"Um I am really anxious and scared. I don't particularly want to talk about why I am anxious and scared but um those emotions are making certain actions that I don't want to do more tempting."

Above is the start of one of the many conversations that have kept me alive. I was what would be termed by psychiatrists as passively suicidal for most of my teenage years – never wanting to be the cause of the end of my life but also not imagining what it would be like to survive and being apathetic at the thought of my death. However, there were times when particular acute anxieties would make these thoughts less passive.

This overwhelming anxiety, fear, and not knowing if I could bear to go on was only aggravated by the school's medical leave policy. The medical leave policy, a policy that exists to this day, notes that students who are experiencing "certain medical and psychological conditions" can be sent home at the behest of the school and barred from campus for a year or until they are deemed to be 'well' again unless they receive permission from the Dean of Student Health and Wellness and are accompanied by a parent (Institution's Student Handbook, 2016; Institution's Student Handbook, 2025). However, it is important to note that within my four years

at this school, I never saw a request by a student who was on medical leave to visit campus to be granted, in part because the Dean of Student Health and Wellness is one of the individuals who, in consultation with the Dean of Students, Medical Director, and Director of Counseling and Psychological Services, decides whether to require a student to be put on medical leave.

Had I reported my own suicidality to the school, or had my suicidality been reported by a teacher, a student listener[7], a dorm proctor[8], a peer, a dorm faculty[9], a college counseling office

[7] Student Listeners are 11th or 12th graders, often between the ages of sixteen and eighteen, who are chosen by the Dean of Student Health and Wellness and in conjunction with staff at the Health and Wellness Center, in particular the Director of Counseling and Psychological Services to serve as unpaid peer support for students. The role of student listeners is to serve as an outlet of advice and referral for students – student listeners also receive two days of training from Counseling and Psychological Services on providing peer support and have bi-weekly meetings with the Director of Counseling and Psychological Services where they give updates on what students have been telling them in the dorm (article on institution's website about the Student Listener Program; personal conversation with a Student Listener about the Student Listener program, 2018).

[8] Dorm Proctors are 11th and 12th graders, often between the ages of sixteen and eighteen, who are framed as unpaid designated student leaders within dorms of ten to fifty students. Dorm Proctors are responsible for working with dorm faculty to resolve violations of school conduct occurring within the dorm including alerting dormitory faculty to violations of major rules, fire hazards, dangerous activity, and "serious health problems" (Institution's Student Handbook, 2025). When a student's health or safety are at risk they must share their concerns with Health services, dorm faculty or campus safety (Institution's Student Handbook, 2025). Depending on the dorm, proctors may also be expected to conduct dorm room inspections that are done when there is concern about possible rule violations, or worry about the health and safety of a student (personal communication with a former Dorm Proctor, 2025).

advisor, or another staff member, I would've most definitely been placed, like I saw multiple peers be placed, on medical leave. The school has a name for this reporting – ASAP, the Academy Student Assistance Program. ASAP is presented as providing "prevention, early identification, intervention, and referral services for students who are having emotional, academic, behavioral, social, or family difficulties, as well as those with substance use concerns." When students are ASAPed, as it was colloquially known, student's academic adviser, parent/guardians and dorm faculty are notified of the ASAP.

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[9] Often faculty at the school are assigned upon hiring to live in a dorm on campus or live off campus and be affiliated with a dorm and serve as a dorm faculty. Dorm faculty range in number from three to around seven depending on the size of the dorm and are overseen by a dorm head, also a faculty member, who lives in an apartment or house connected to the dorm. Depending on the architecture of the dorm, other dorm faculty may live in apartments connected to the dorm. Dorm faculty are tasked with maintaining student norms of conduct in the dorm, serving as academic advisors to students assigned as their academic advisees in the dorm, authorizing food deliveries for students, reporting dorm maintenance concerns, keeping track of students within the dorm (including if students are leaving campus), offering written statements for Community Conduct Committee hearings on behalf of students, deciding if/when students are allowed to have visitors from other dorms in common rooms or in their rooms, policing the policy that 9th and 10th grade students must be in their room with the lights out by 10:30 PM (unless they have requested "late lights" permission from the dorm faculty on duty) and policing check-in policy that dictates when students of all grade levels should be back in the dorm by (Institution's Student Handbook, 2025).

The medical leave policy is portrayed in the school's student handbook as allowing a student to receive medical or psychological treatment at home or off campus that cannot be provided by the school or cannot be provided while the student is a full-time student and/or living in a dormitory. However, in actuality it became a system to push students who were deemed too Mad or too disabled for the institution off of campus until they were either deemed to be rehabilitated or were deemed too ill to attend. This is in part because students are only allowed to be on medical leave for three terms – one academic year. After that one year, a student would be required to withdraw, akin to expulsion with the added note that students who are required to withdraw are not allowed to return to campus for one year without the prior written approval "of the Academy" [10] (Institution's Student Handbook, 2025). Additionally, for many students a year away from the school would not allow for medical care. With the exception of international students, the school does not provide a health insurance plan for students. The plan for international students, the Student Accident and Sickness Insurance Plan, does not cover off-campus mental or physical health care, with the exception of hospitalizations while they are students (therefore not when they are on medical leave). This means that students would have to

[10] It is interesting to note that unlike the decision for a student on medical leave to return to the academy being decided by the Dean of Student Health and Wellness, the decision for a student who has been withdrawn to be allowed to return to campus is vaguely left up to "the Academy" (Institution's Student Handbook, 2025). It is not clear who the student would petition or ask to be allowed to return to campus or at which level this decision is made, making it virtually impossible for students to know how they would be allowed to return to campus and thus making this requirement to withdraw essentially being barred from the school for a year.

rely on pre-existing healthcare coverage from their parents – which even for students who want access to mental and physical health services often does not cover most of the cost of out-patient or in-patient mental health care or intensive specialist physical healthcare. For students on Medicaid coverage of mental and physical health services would vary depending on the state they are from with Medicaid providers often having limited openings for children's mental and physical health care and large caseloads (personal communication while working as an intern for the Wisconsin Department of Health Services Bureau of Prevention Treatment and Recover Division of Children's and Integrated Mental Health, 2021). For low-income students and students in other precarious positions – students who were 2SLGTBQIA+ and either not out to their families or who lacked familial acceptance, students who feared parent reactions to being put on medical leave, or students whose families would not receive the news of their child being Mad or disabled well – there was a palpable fear of being 'found out' as being either disabled or Mad and being ASAPed[11]. This intensive surveillance led to lateral surveillance.

As previously stated, lateral surveillance was defined by Mark Andrejevic (2004) in the paper "The Work of Watching One Another: Lateral Surveillance, Risk and Governance." Lateral surveillance was defined as surveillance that occurs between spouses, friends, relatives, co-organizers or other individuals within peer relationships (Andrejevic, 2004). Andrejevic (2004) frames lateral surveillance as simultaneously democratizing surveillance by enacting surveillance

[11] This fear of intensive surveillance of the ASAP and Medical Leave systems lead to some students jokingly referring to the Health and Wellness Center as the Wealth and Hellness Center out of an understanding that unless you were wealthy the center really served as a space to push students dealing with non-acute medical concerns into Medical Leave.

outside the power of the state but also as a mechanism states can use to offload surveillance duties onto the individual citizen. This offloading occurs when individuals internalized state surveillance apparatuses to surveil their own behaviour and then turn those internalized norms of surveillance onto others (Andrejevic, 2004). Within the system of surveillance at the school, once students internalized self-surveillance, out of a fear of getting removed from the school, they also enacted lateral surveillance to ensure their friends did not get removed. One pertinent example of this is the one I started the section with, where a friend agreed to talk me through my active suicidal ideation and then follow up with me for days after to ensure I wasn't displaying my active suicidal ideation in ways that would result in me getting put on medical leave – an experience that would have only heightened my suicidality at the time. However, this lateral surveillance occurred even when it was not requested by the student who was deemed to be at risk of being reported. During our senior year, a friend and I would go on weekly Saturday walks on paths in the school's couple acres of forest. These paths allowed us space to talk outside of the prying ears of school staff and faculty about one of our other friends, who was also this friend's roommate, who was experiencing bouts of depression, anxiety, and self-harm. On these walks we would strategize safety plans including requesting that our friend give any sharp objects stored in their dorm to us to limit anything they could create visible self-harm scars with, share information with each other about which one of us had checked in with this friend and when, and create plans to clean this friends room (despite COVID-19 restrictions) so it would not look like a mess that could be tied to depression when dorm checks came around. We engaged in this lateral surveillance because we were aware that this friend's family lived under the poverty line and that going home would only increase the depression, anxiety and self-harm behaviours. These walks in the woods gave us space to discuss the anxiety we felt as being the ones who

provided this care while also knowing we were not trained mental health practitioners and dealing with the anxiety of holding that while we should not be anyone's first choice of carers, we were in a system of pervasive surveillance, the only form of care that would not do this friend outsized harm.

Illustrative Case #2

From 2022-2025 I attended a large public university located in the northern Midwest of the United States while completing my B.A. Beginning in the 2022-2023 academic year, I served as a Resident Assistant, one of around 200 student staff who were employed by University Residence Life to live in the residence halls with students, create student programming, act as a facilitator of community, and ensure compliance with the university rules and regulations. I subsequently served in this role in the 2023-2024 and 2024-2025 academic years, with the exception of the spring 2024 semester when I was on a 'study away' program.

During my time working in Residence Life I worked in a small dorm, with approximately 150 student residents. I was one of four Resident Assistants in the building and was the primary Resident Assistant for 30-50 students each year. These are the students I most directly worked with. The student population I worked with was primarily first year students between the ages of 17-19, most of whom lived in one of our two Gender Inclusive Housing units. The average age of an undergraduate student during my time working at this university, according to university reported statistics, was 19.9. The vast majority, around 75%, of the students I directly worked with, identified as 2SLGTBQIA+. Additionally, the majority of students who I worked with were white. For context, during my time working at this university around 60% of the university undergraduate population was white, according to university reported statistics. Also, around one

third of the students I directly worked with noted to me they either had academic accommodations and/or identified as disabled with the vast majority of those who did identifying as having a mental health diagnosis or disability. This is compared to approximately 11% of students registered has having accommodations with university accessibility services, according to university reported statistics. I will note part of the reason for this disproportionate identification with/disclosure of disability or accommodation status may be because I was the only visibly disabled student staff in the Resident Assistant role. This led to students often disclosing their disability status to me in order to get help applying for accommodations or enforcing their already granted accommodations in class settings.

In this illustrative case, I will discuss how the system of Intentional Interactions was a system of surveillance of students, enacted by student employees, that was framed as providing care for student mental and physical wellbeing but often served to create a level of plausible deniability of liability for the university if a student were to attempt to harm themselves or others, and subsequently alienated students from themselves and did not provide students with avenues to comprehensive support. Additionally, I will discuss how Intentional Interactions were connected to the Student of Concern Reporting Form and how the guidance given to those utilizing this form defines certain students as non-rhetors about their own experience and wellbeing and as insurmountable threats to the university that must be met with police and carceral involvement while other students are deemed as able to be managed and rehabilitated. Finally, I will discuss how once students learned they were being surveilled by these systems, namely Intentional Interaction and housing check-in text message systems, they moved to voice dissent to this system of surveillance through (1) remaking the system of surveillance into a

system of institutional complaint or (2) through intentionally giving the surveillance system data that is either not useful or not legible to it.

Intentional Interactions

University Residence Life continually framed the Resident Assistant role as one of being the 'eyes and ears' of the university in the residence halls. As student staff, we were framed as the front lines of university response to student wellbeing including student mental and physical health. During our twice yearly trainings we received instruction on topics varying from how to respond to a student showing signs of potential suicidal ideation – including attempting to discern if a student had a plan and means to attempt suicide – to how to respond to students passed out in our residence hall from alcohol consumption – monitoring student vitals whilst calling emergency services. Part of this surveillance of student wellbeing included conducting what were called Intentional Interactions.

Intentional Interactions are a common practice across University Residence Life offices (personal communication with participants in the 2023 University of Northern Iowa Residence Assistants Conference, 2023; personal communication with University Residence Life supervisors, 2022-2025). While the vary in name depending on the academic institution, Intentional Interactions often serve the roles (1) of creating a quantifiable system to ensure student resident life workers are actually connecting with the students on their floor and (2) creating a written record of student interactions that can be referred back to if problems arise with the student – whether it be concerns internal to Residence Life like a roommate dispute or request for a room change or external including Student of Concern or other similar reports from other university staff. At the university I worked at, Intentional Interactions were 10 to 15 minute conversations expected to happen in person on a 1:1 basis, with the themes of the conversations

recorded through an online reporting form afterward. We were expected to complete two Intentional Interactions with each student on our floor per semester. The expected content of Intentional Interactions changed each year depending on guidelines given to us during student staff training. My first year on the job we were given freedom to talk to students about whatever the student wanted, with the exception of promoting drug use, alcohol use or other behaviors that would violate the university code of conduct and with the expectation that we would write a brief summary of the conversation. My second year, after being told that our Intentional Interactions were not focused enough on supporting student growth, we were given the guidance of recording what resources on campus we connected students with and recording themes (for example – home sickness, academics positive, academics negative, feeling connected to community, not connected to community) in addition to a general summary of the conversation. My third year, we were given specific questions to ask the students during Intentional Interactions, including asking our students if they felt like they were doing as well as other students on the floor and what "connection points" they had made on campus. After our direct supervisor and staff agreed these questions were unnatural to ask our students and often caused us to have worse interactions with our students, we were allowed to go off script as long as we generally asked students about how they were feeling about their academics, social life, and wellbeing. We were expected to put their answers to these questions in our reporting form along with a summary of the conversation. These summaries of conversations were put into a student's Residence Life file. The Residence Life file served as a documentation of how the student was doing – it would be used internally to Residence Life to track student conduct, provide accounts of roommate disputes, and to track general wellbeing of students across a dorm.

Within this system, Intentional Interactions were framed as providing care for student mental and physical wellbeing through a surveillance of the student – the idea that if the university could get more information, more surveillance, of a student that they would be able to figure out which students were not doing well. However, there was also an understanding from those in the system that we were not receiving correct information. For instance, as student Residence Life employees we were assured by our supervisors that there will be students on our floor who just do not want to talk to us either because they are shy and quiet, or because of the pervasive narrative around student Residence Life employees proliferated in popular media about dormitory experiences that paints student Residence Life employees as killjoy narcs. We understood that if you were to ask a student "how are your classes going," most students would in a knee-jerk reaction respond that they are doing well or at the very most they would bemoan an upcoming test or assignment. It was posed as the pinnacle of our skills if we could get students to admit to us that they were going out to drink or that they were having thoughts of self-harm. So, if we knew and our bosses knew that this data was at best incomplete and at worst inaccurate, what was it collected for?

Legal liability. If a university knows a student is experiencing thoughts of harming themselves or others, they are thought of as having both a moral and ethical responsibility to intervene. Margaret Price (2011) discusses this phenomenon of legal liability in her book *Mad at School: Rhetorics of Mental Disability and Academic Life.* Price (2011) discusses the rhetorical creation of legal liability for student Madness in the late 2000s in the aftermath of the school shootings at Northing Illinois University and Virginia Tech. In both shootings the academic writings of the shooters, Steven Kazmieraczak and Seung-Hui Cho respectively, both of whom were students at the time the mass shootings occured, were analyzed and pathologized as signs of

Madness and violence (Price, 2011). Price discusses how Edward Falco, a professor at Virginia Tech who taught Cho in a playwrighting class said in a statement after the shooting and following discovery of seemingly violent writings by Cho, “We treated him like a fellow student, which is what he was. I believe the English department behaved responsibly in response to him. And please hear me when I say this: It was our responsibility, not yours” (Price, 2011, p. 174). This statement, while it notes that Falco believes the English department acted responsibly still places the responsibility for surveilling students for signs of Madness and potential plans for violence on the university.

In the case of transgender and gender non-conforming students, this association of Madness with liability and danger has only become more pronounced in the last five years as the pathologization of school shooters in the United States has become enmeshed with the pathologization of transgender people with both the assassination of Charlie Kirk at Utah Valley

University in September, 2025[12] and the 2023 shooting at The Covenant School[13], inciting media rhetoric and speculation on whether the shooter identified as transgender or was motivated by being close to transgender people.

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[12] In the case of Charlie Kirk, while the shooter Tyler James Robinson is not transgender, soon after the shooting Utah Governor Spencer Cox noted that Robinson was "deeply indoctrinated with leftist ideology" which went against the political views of his conversative family (Timotija, 2025). Part of this supposed ideology was Robinson's support for his transgender roommate, with whom he was possibly in a romantic relationship with (Timotija, 2025). Additionally, there was also speculation that of some of the memes engraved on the ammunition used by Robinson might not be leftist internet references but rather be groyper references(Toledo, 2025). Groypers are a far right, Christian national, anti-immigration political group led by political commentator and January 6th rioter Nick Fuentes who often criticize the republican party under Donald Trump for not being far-right enough (Toledo, 2025). However, Robinson being a groyper did not erase the connection to transness with some online commentors claiming that groypers' hatred of women could allow of Robinson to have a trans partner. Additionally, early reporting by the Wall Street Journal noted the bullets used to shoot Kirk were engraved with "transgender, antifascist ideology" (Gurman & Fanelli, 2025). The Wall Street Journal later added an editor's note to this article to note that there is no indication that the ammunition included "any transgender references" (Gurman & Fanelli, 2025). The Charlie Kirk shooting, however, has remained within the popular imaginary of internet culture, and the possible trans connection with it, with songs like the presumably AI-generated song "We Are Charlie Kirk" by Spalexma being used by both leftists and far-rights individuals alike on TikTok.

What would it look like if a student was deemed to be Mad through Intentional Interactions? And what happens when about students who do proactively seek engagement in psychiatric systems by asking for Residence Life help in connecting them with that care? Students were not provided with care. Based on my own experience along with the writings of Mimi Khúc (2024), Adam Davis and Kahleen Clarke (2025) and Subramaniam et al. (2025), the academy in its current form is fundamentally maddening. It is a system that made us ill and sick. I will note, however, that not all students experienced themselves as Mad or sick, and felt it alienating to be labeled as such by the institution. For instance, I had a resident who was struggling academically after being denied accommodations they had received in high school by the school's Disability Resource Center. In particular, instead of meeting the student with compassion through the struggles of transferring from an Individualized Education Plan system that was mostly guided by the student's parents to a university accommodation system and implementing stop-gap measures like temporary accommodations or working with the student to discuss what accommodations were open to them at the university, a relatively new member of

[13] The Covenant School is a parochial elementary school in Nashville, Tennessee. The shooter, Aiden Hale, was a 28-year-old former student of the school who is a transgender man. Media reports tied reports of Hale's "childlike obsessions with staying a child" with Hale's fascination with school shootings dating back to 2017, Hale's reported emotional disorder, and Hale's transgender identity (Hale, 2025; Zdanowicz, 2023). There was speculation following the shooting on whether Hale being trans could've led Hale to hold resentment for the school and its religious views that could've been a motivation for the shooting – however, this theory was later proven inaccurate in police reports (Hale, 2025).

the Disability Resource Center staff denied the student's request for accommodations right before the beginning of the fall semester, after the student had already moved onto campus and away from their medical support team, with the note that the student needed more up-to-date documentation of their diagnosis. Midway through the fall semester, the student, unable to access documentation of their diagnosis, got reported by a professor through the Student of Concern reporting form, which will be discussed more later. This, in concert with my documentation of the student as withdrawn and not having engaged much in the Residence Hall, led to daily and then escalating to three-times-daily emails from both my supervisor and the Dean of Students attempting to get in contact with the student, and finally lead to a directive that I had three days to get in contact with the student before the university explored potential police involvement. Once I was able to get in contact with the student, I learned about the student's struggle with accommodations and how the student felt alienated from how they were being viewed by the university because while they knew access to proper accommodations would allow them to engage in class and in the dorm, they were labelled by the university as at-risk, Mad and a potential liability.

Even when students report their madness, illness, and sickness, they are often not provided with timely or adequate care. During summer and winter break student staff training, often the presentation by University Mental Health services on the services they provided would be met with questions from student staff employees about why they themselves or their residents had experienced three to six month waits from originally contacting mental health services to having their first appointment, even after their students had reported to them passive suicidal ideation. Often these comments were scoffed at and noted as student exaggerations, with a comment that if students were in crisis or active suicidal ideation they would be able to get in the

next day. However, it was reported by the Director of Mental Health Services – with pride – to Student Government that Mental Health Services, which was in part funded by Student Government, had been able to decrease the time between when a student first called them and when a student received a follow up "access appointment" – a non-clinical appointment meant to assess the student's needs for care and whether they could receive care through University Mental Health Services – to fifteen days on average.

In my senior year as a student, the 2024-2025 academic year, University Mental Health Services introduced the new service of an "embedded provider" who was supposed to serve the increased mental health needs of student Residence Life staff and be able to meet with students immediately after they had experienced a stressful or disturbing work scenario. However, this service did not meet these needs. On November 6, 2024, I was told in a meeting with my supervisor that a student under my care –one of my residents – had attempted suicide while off campus following the announcement of the results of the 2024 Presidential election and was still in critical condition. I was given the offer of a letter from the Director of Residence Life to get an immediate appointment with our embedded provider to help process the event for both my own mental health and so I could be in a good place to help the student reintegrate back into campus, which I accepted. However, even with a letter from the Director of Residence Life, I was told that the earliest time I could meet the embedded provider who was employed by Residence Life was five days later on November 11, 2024 because the provider had been pulled in to help on other urgent cases. And when I finally met with the provider, after meeting with a non-housing embedded provider in the interim only after a phone call from the Director of Residence Life to the Director of Mental Health Services, I was asked by the embedded provider, multiple times, if a lack of attention on my part could've played into the student's suicidal ideation. This

experience of ‘care’ felt alienating. Rather than being met with compassion and understanding as a student who was working through their own emotional response to the attempted suicide of a student they were supposed to take care of and getting ready to ease that student back into the university environment, it felt more like an attempt to create a trail of documentation where any ongoing medical impacts from the student’s attempted suicide could be pinned on my supposed lack of attention to the student rather than the university.

While the experience I had with University Mental Health Services wasn’t related to an Intentional Interaction report, it provides a damning image that the surveillance of students through Residence Life as a system as a whole is not aimed at providing care to students in want of mental health care – as seemingly a direct referral and phone call from the Director of Residence Life would have some weight in providing a student with urgent care. Rather, these systems are aimed at identifying students who are seen as potential burdens, legal liabilities, or threats to the university and either sweeping them into administrative reporting structures, as will be discussed more in the discussion of Student of Concern Reporting, with the intent of weeding these students out of the university, or to ensure legal liability of any potential actions of these students that could be faced by the university is covered up under a veneer of “well they said they were good when the Student Residence Life employee asked them.”

Student of Concern Reporting

The Residence Life file, formed mostly through Intentional Interactions was also used outside of Residence Life to determine if a student was doing well. One of the instances where it would be used is if a professor, teaching assistant, university staff person, or fellow student filed a Student of Concern report. Student of Concern reports at this university are situated as being part of the reporting mandate for faculty and staff. However, the form is open to anyone on

campus to fill out, including students. However, despite the form being open to everyone, in my experience the vast number of reports came from faculty and staff.

The Office of Student Assistance and Support (2026), formerly the Dean of Students Office, defines a student of concern as "any student who may be experiencing personal, financial, or health challenges. They may display behaviors that interfere with their own success or disrupt the learning of others." The office also includes a list of examples of concerning behaviors including:

> missing classes, meetings or not responding to communications; navigating personal challenges with broad impacts on student; experiencing physical or mental health challenges; significant change in behavior; comments that are inappropriate or irrelevant to class discussion; unable to control emotions; poor hygiene; appears intoxicated or smells of alcohol; appears high or smells of marijuana; appears tired or is constantly falling asleep in class; very anxious; concerning writing or art; extreme change in weight; extreme change in appearance; unusual bruising or other injuries; interrupting class discussions; interfering with other students' ability to learn; making threats or threatening behavior; talking or writing about suicide (Office of Student Assistance and Support, 2026).

This list of concerning behaviours situates the Mad student as suspect, especially as many of the characteristics on this list align with pathologized and sanist envisionings of Mad people as unstable, unproductive non-rhetors (Price, 2011). Margaret Price (2011) in her book *Mad at School: Rhetorics of Mental Disability and Academic Life* discusses how rhetorical machinery that situate students and academics as necessarily rational, critical, present, participatory, productive, collegial, and adherent paint a sanist envisioning of the student and the academic as

not Mad. Price argues that this sanist envisioning of who is the student has been used to push Mad students and academics out of the academy, to make madness within the academy into a site of suspicion, surveillance and fear, and to utilize psychiatric logics to pathologize students. Price (2011) notes that Mad individuals are constructed as non-rhetors by psychiatric rhetoric, and that this construction can move beyond the boundaries of psychiatric institutions into the academy since academia is grounded in an assumption that scholars are speaking from a shared rational viewpoint that individuals labeled as Mad are marginalized from. This situation of students who are labeled as mad as non-rhetors and other from academia is also used to bolster racism and white supremacy in the academy. As noted by Price (2011), often racialized students are accused of being Mad when they are presenting the extent of violence and systemic oppression, both current and historical, experienced by racialized peoples. Because of this, racialized students often work to situate themselves as rational rhetors in ways that reinforce rationality as a valued trait in academia (Price, 2011). This usage of allegations of Madness against racialized students is a form of the ideal of the normal student being used to enact White supremacist aims as the normal student is imagined as non-Mad and as not experiencing the violence of systemic oppression and thus reactions to that violence are framed by the academy as Mad and as non-normative.

Additionally, the characteristics listed as concerning by the Office of Student Assistance and Support are highly subjective, leaving room for those with a reporting requirement to decide whether a behaviour is occurring or is rising to the level of possible concern. For example, as someone with multiple energy limiting conditions – including Hashimoto's thyroiditis, which meant I needed to put energy into minimizing migraines in situations with overhead lighting and reading (for instance a lecture hall), and the fatigue of hypermobile Ehlers Danlos Syndrome –

there were some class periods I dosed off during, especially those in warm large multi hundred person lecture halls that were hosted in the mid-afternoon. My apologies to my professor for the course on the American Presidency where these unintentional naps frequently took place. However, to my knowledge, I was never reported as a student of concern, despite "consistently falling asleep during class" as is evident in my course notes missing sections of course material. While I could guess at any number of reasons I was not reported, maybe because he did not notice, or did not care for the Student of Concern Reporting system, my best guess was that I was performing other aspects of non-disability and non-Madness – I stayed after class to ask engaging questions, I would frequently answer questions while I was awake to the point where I was apparently to the recollection of my peers participating more in discussion than most of the class, and I got 91% as a final grade in that class. In this case, my ability to perform the role of the non-disabled non-Mad student potentially compensated within the mind of the professor to the point where I was not reported. However, we can easily imagine scenarios where students who are either deemed as or who are incapable of performing the role of the non-disabled and non-Mad student are reported.

In the case of who gets defined as a Student of Concern concerning behaviors, Madness and disability get made into topoi. Lawarence J. Prelli explains that topoi, derived from topos, are lines of argument that imbue credibility through relying on concepts (topos) that are shared by many people yet are often not defined. Using topos imbue credibility by situating the individual rhetor in the in-group that shares this unspoken definition (Price, 2011, p. 5). Margaret Price (2011) notes that often topoi are invoked to reinforce dominant values. The Office of Student Assistance and Support provides examples of, but never firmly defines the edges of, what constitutes someone as a student of concern. This creates a situation where who gets

deemed a student of concern – as illustrated in my example of me falling asleep in class – is a 'you know it when you see it' determination of individual instructors. To provide a comparative example, a common topos is freedom. We may be able to give examples of freedom – freedom of speech, freedom of assembly, bodily autonomy – but it is harder for us to give a definition of what constitutes someone as free. For instance, many legal and philosophical debates have hinged on the question of whether freedom includes freedom to engage in an action that infringes on the freedom of another. In this case we can describe actions or examples of a student of concern – a student who writes about suicidal action, a student who frequently falls asleep in class, or a student who stands up and yells in the middle of class. However, we do not get a direct definition of who is a student of concern, making the determination of who is and isn't a student of concern based only on the views of professors or others who are reporting a student. Additionally, being able to assert this topos of 'student of concern' lends those reporting a student a level of credibility through defining themselves within the norm of academic functioning and defining the student they are reporting as outside of that norm.

While the Office of Student Assistance and Support (2026) notes that those looking to file a report should first check in with the student and provides a guide to talking with students, there is no requirement that individuals check in with a student before they report them. The guide regarding talking to students is aimed towards a faculty audience and includes additional guidance for students that it notes have "specific concerns" including "disoriented/psychotic behavior," "student anxiety," and "discussing suicide." In the case of the additional guidance pages for "severe disorientation or psychosis" and anxiety, they both list the symptoms of psychosis and anxiety respectively. However, there is a difference in guidance (Office of Student Assistance and Support, 2026). For students with "severe disorientation or psychosis," the

guidance on what to do is to immediately call the University Health Services: Mental Health Services crisis line, to tell the student you are planning to get them to a ‘safe’ environment, and to either walk the student to University Health Services or to arrange for a police escort through calling 911 to a local hospital emergency room (Office of Student Assistance and Support, 2026). There is a note below this of what you should avoid doing which includes “assuming the student will be able to care for themselves. Agitating the student. Arguing with unrealistic thoughts. Assuming the student understands you. Allowing friends to care for the student without getting professional advice. Getting locked into one way of dealing with the student” (Office of Student Assistance and Support, 2026).

In contrast, in the guide for talking to students with anxiety, only physical symptoms are presented as symptoms whereas mental symptoms are presented as “anxious thoughts” and “anxious behaviors” (Office of Student Assistance and Support, 2026). Additionally, the guide regarding students with anxiety begins with recommendations including talking to the student in private, talking in a calm and soothing manner, focusing on the information at hand, and helping the student develop an action plan to address their concern (Office of Student Assistance and Support, 2026). As an after note, it notes you can refer the student to University Health Services: Mental Health Services but the phone number given is not the crisis line number, rather it is the non-crisis scheduling number (Office of Student Assistance and Support, 2026).

These guides place students as having anxiety temporarily and anxiety as something that can be quelled through discussion and a possible referral to Mental Health Services. Whereas students experiencing psychosis are defined by their “disoriented/psychotic behavior” and are instantly seen as both not knowledgeable about themselves but also as an immediate threat to themselves or others. Additionally, for students who are displaying “disoriented/psychotic

behavior," this state of not being knowledgeable about themselves is assumed to not just apply to them but also to those close to them as the guide instructs individuals to not "allow friends to care for the student without getting professional advice" (Office of Student Assistance and Support, 2026). While students who are experiencing symptoms of anxiety are seen as still maintaining self-insight, students who are seen as displaying "disoriented/psychotic behavior" and their support networks are seen as not having insight into themselves and rather it is deemed that the only individual who can truly address this behaviour is a licensed mental health provider. This differentiation in treatment of anxiety and psychosis echoes histories of Madness. Following the move towards the promise of de-institutionalization in the 1970s, medications including Prozac, Ritalin, Valium, Librium, and tricyclics rose in popularity marketed as allowing the anxious and depressed Mad person to become happy, docile, and assimilated into saneness (Menzies et al., 2013, p.4). The usage of psychiatric medication created a divide between the curable Mad person who was able to assimilate into saneness through the use of medication and talk therapy and the uncurable Mad person whose madness was seen as not cured through the use of medication and thus was positioned as incurable threat (Menzie et al., 2013). Students who were deemed to be unrehabilitable, either through psychiatric measures or through self-surveillance, are defined as threats to the university – this process of defining students as threats is evident in the guide on how to respond to students displaying "disoriented/psychotic behavior" to engage in incarcerating the student either through involvement of the police or through psychiatric incarceration through involuntary admission to their University Health Services or to a hospital. Defining students as threats allows the university to then subsequently either advise the student to disenroll or place the student on health-related leaves – in either case a measure to push students out of the definition who is within the imagining of the 'normal'

student and instead placing the student as an insurmountable threat to the university through sanist rhetoric.

Responses to Surveillance – We See You Seeing Us

As previously mentioned, as a university Residence Life student employee, I was responsible for conducting Intentional Interactions with each student under my direct supervision in the residence hall twice each semester – ranging from 60-100 interactions in total per semester – and provide a written summary and documentation of each of these interactions. It was clear from our first student staff training the summer before my first semester on the job started that the intent of Intentional Interactions were to document wellbeing of the student, and we were informed that the summaries of our interactions would be included in a student's Residence Life file for use in Student of Concern Reporting situations along with general internal housing reporting on a student – for instance if a student were to be part of a roommate dispute or housing disciplinary case, or were to request a room change. As a new Residence Life student staff, I was also told by more experienced returning staff about troubles they had faced in getting meaningful Intentional Interactions with students, and tips for getting interactions like how you needed to make sure to get interactions at mandatory all-floor events or pair interactions with giving students candy to entice shy or disengaged students to talk to you. I decided in my first year as a House Fellow to take the path, because I was never explicitly told I could not, of telling students that it was part of my job to interact with them at least twice a semester and to let housing know about how they were doing through these interactions. I used this tactic the following two years I was in the job as well. I thought that by doing this I would demystify a little bit of the slightly off putting over friendly Resident Assistant stereotype, while also getting leverage with students by saying 'hey if you are not talking to me, it will become a problem with

my boss.' What happened was that once students were aware they were being surveilled, they moved to re-appropriate the system of surveillance through becoming willful subjects.

Sara Ahmed (2014) in her book *Willful Subjects* defines willful subjects as individuals who refuse to submit to the tactics of domination exercised by the ruling class. Ahmed is also keen to note that individuals are afforded different amounts of noncompliance with the will of the ruling class based on their class proximity. For instance, as mentioned earlier, my being able to perform non-Madness allowed me to not be reported as a student of concern because I was seen as proximate to the non-Mad professor. In the case of my residents, acting as willful subjects and re-appropriating the surveillance system occurred in two key ways: (1) turning the system of surveillance into a system of complaint and (2) giving the system of surveillance non-usable or non-parseable data.

Once students knew that Intentional Interactions served as a system of surveillance, they were able to turn it into a system of complaint. Students, through my description of the Intentional Interaction system, knew that my supervisor would read my Intentional Interaction summaries and could forward them to other members of Housing and Residence Life. While students knew this was, as previously noted, unhelpful in getting mental health care, they decided to report other things through the system. For instance, once I had a student knock on my door at 11 PM at night to let me know that they were upset because it was the third day in the row the dining hall nearest to our dorm had served uncooked chicken with sauce on it as one of the primary main dishes for dinner and lunch, and they showed me photographs they had taken of the chicken being completely raw when cut open. They started the conversation with "Emmett can you let housing know" and ended the interaction with a note that I should document it as an Intentional Interaction. In this case the student was purposefully turning the system of

surveillance of Intentional Interactions into a system of complaint, knowing the university would read a report that noted student upset. And the student was correct – a couple days later we had a staff meeting about the increased reports of raw chicken in the dining hall and how Residence Life had reported it to the Director of Dining.

Students were also able to re-appropriate Intentional Interactions and other systems of surveillance by giving these systems data that was not useful to the university and in turn served as the students saying that they saw the university seeing them and were not going to give the university what they want. Often these protests of the surveillance infrastructure were not necessarily activist in nature and more fell along the lines of students seeing how much they were able to get away with. In my first year as a Residence Life employee, one of my residents told me to tell Residence Life that their "cat [had] feline AIDS but [was] doing okay" along with a description of the symptoms of feline AIDS. The next year, in our summer Student Staff Training the example of that interaction was used by an Assistant Director of Residence Life who was running a session on Intentional Interactions to describe why there was a change in how we would report Intentional Interactions which included recording themes of the conversation to attempt to make our conversations more focused on supporting student growth and engagement with campus instead of seemingly superfluous topics, like feline AIDS.

Even when there were attempts to tailor surveillance systems, students still persisted in providing unparseable or useless data. In my senior year, and final year working as a student Residence Life employee, Residence Life rolled out a text system where students would receive a text around the time of mid-term exams each semester asking them, "How are your midterms going?" and then prompting them to rate their experience of their midterms on a scale of one to three where one would correspond to okay, two was good, and three was great. The rating a

student responded to this text with would change the student's profile icon on RoomPact, the Residence Life management system we used that contained a Student's Residence Life file, to red, yellow or green respectively. This colour change was meant to serve as a visual cue to student staff on which students to check-in with. In very predictable ways, this system failed on multiple fronts – around 90% of our students responded "okay" – a very predictable response from a university student in the throws of midterms – meaning the vast majority of our students icons were red, making the system of identification of who was struggling useless. Additionally, the text messaging platform did not limit what a student could input. This led to students responding with text like the full script of *The Bee Movie* or with copy and pasting random strings of words which Residence Life Supervisors were then required to read through to ensure there was not a threat to hurt others or themselves, or a report of sexual assault or misconduct hidden in the long text messages.

Once students knew about the system of surveillance, they were able to re-appropriate it to either meet their needs as a form of complaint or to give it useless information that served to both be amusing to the students and let the surveillance system know that the students saw the system seeing them. However, as previously noted, this was not taken as a concern or threat to the system because care of the students through surveillance was viewed as the systemic weeding out of Mad students who were deemed to be liabilities, threats, or burdens, even in performing marginal dissent against the system, students were seen as still performing the roles of non-Mad and non-disabled students and thus were not seen as liabilities, threats or burdens that needed to be addressed.

Conclusion

This paper poses a theoretical framework through we must view the interaction of seemingly or allegedly Mad and disabled students with systems of care and wellbeing in post-secondary and secondary schools. We live within a longstanding Western hegemonic medical paradigm that understands medical care as the quantification of bodies as compared to an idealized normative body and the bringing of these bodies into alignment with that norm, described as a model of surveillance as care. Within the medical care setting surveillance as care often leads to alienation of individuals from themselves, reinforces White supremacist, eugenical, cishetero, patriarchical, sanist, and otherwise oppressive health norms, and often works to create forms of quantification that are not in line with patient experience. This feeling of alienation from oneself is a part of Marxist conceptualizations of alienation. Alienation is a broader outcome of how living under systems of surveillance capitalism the surveillance of our bodies is used within capitalist logics of accumulation to both ensure we remain productive labourers and to derive profit from us. Futhermore, medical care can simultaneously not be read outside of systems of capitalism and medical care is not the only system that employs the paradigm of surveillance as care. An example of another system that employs this paradigm of surveillance as care is the carceral system where the panopticon came out of early views of prison reform as a way of rehabilitating prisoners through inducing in prisoners a self-surveillance of their behaviour.

As an illustration of how surveillance as care plays out within the experience of Mad and disabled students within post-secondary and secondary school systems, I offered a blended crip autotheoretical and institutional ethnography insight into how in a secondary school disabled and Mad students were defined outside of the idealized normal imagining of a student through

admissions processes and institutional rhetoric then the Student of Concern reporting system was used to serve as a form of surveillance once students were admitted to the institution, to nominally care for the student. This system induced both self and lateral surveillance in myself and other students leading students to provide untrained mental health care to each other to avoid institutional surveillance. Additionally, this system was shown to not just be limited to the private secondary school environment with a discussion of how within a public university there were similar structures through Intentional Interactions of surveilling students to nominally provide care but in actuality to provide a flagging of students deemed to be Mad or disabled, regardless of whether this determination was in line with student's perception of their needs and wellbeing. This discordance between the institution's perception of students' wellbeing and students' lived experience was experienced as alienating. I discuss how once students were alleged to be Mad or disabled the Student of Concern Reporting form was used to weed students out of the institution who were not able to present as non-Mad or non-disabled. When students were made aware of this surveillance there were attempts to re-appropriate the system through acting as willful subjects through turning the surveillance system into a site of complaint or into engaging in often-absurdist tactics to show the surveillance system that they saw it seeing them. However, this re-appropriation never undermined the goal of the system which was not to provide students with care and was rather to avoid legal liability in the event of harm or death of a student.

In writing this paper I don't wish to leave you with a feeling of despair – that nothing can be done and that disabled and Mad students will continue to get pushed to the margins of academia. Rather, in framing these systems as insidious and as non-unique, I hope to open up a reframing of how surveillance within the medical system and educational systems cannot be

dismantled without a discussion of its capitalist, White supremacist, and eugenical underpinnings.

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References

Ahmed, S. (2014). *Willful subjects.* Duke University Press.

Andrejevic, M. (2004). The Work of Watching One Another: Lateral Surveillance, Risk, and Governance. *Surveillance & Society*, 2(4), 479–497.

Beirne, P. (1987). Adolphe Quetelet and the origins of positivist criminology. *The American Journal of Sociology*, *92*(Mar 87), 1140–1169.

Campbell, M. (2005, November 1). Reflections: We need to return to the principles of Wahkotowin. *Eagle Feather News.*

Caponi, S. (2013). Quetelet, the average man and medical knowledge. *História, ciências, saúde--Manguinhos*, 20(3), 831–847.

Cardinal, H. (2007). Nation-building: Reflection of Nihiyow (Cree). In P. De Pasquale (Ed.), *Natives & settlers, now & then: Historical issues and current perspectives on treaties and land claims in Canada*. University of Alberta Press.

Carrigan, D. (1994). *Crime and Punishment in Canada: A History*. McClelland and Stewart.

Chapman, C., Carey, A. C., & Ben-Moshe, L. (2014). Reconsidering Confinement: Interlocking Locations and Logics of Incarceration. In L. Ben-Moshe, C. Chapman, & A. C. Carey (Eds.), *Disability Incarcerated* (pp. 3–24). Palgrave Macmillan US. https://doi.org/10.1057/9781137388476_1

Crawley, L.W. (1993). Evidence-Based Medicine: A New Paradigm for the Patient. *JAMA : The Journal of the American Medical Association*, 269(10), 1253–1253. https://doi.org/10.1001/jama.1993.03500100051021.

Davis, L. (1995). *Enforcing normalcy : disability, deafness, and the body*. Verso.

Davies, A. & Clarke, K. (2025) Mad, Maddened, and Maddening: A Mad Duoethnographic Exploration of Undergraduate Education. *Canadian Journal of Disability Studies*, 14(3), 136-172.

Debnath, S. (2020). Concept of Alienation in Hegel's Social Philosophy. *Journal of Indian Council of Philosophical Research*, 37(1), 51–66. https://doi.org/10.1007/s40961-020-00189-4

Dewey, J. M., & Gesbeck, M. M. (2017). (Dys) Functional Diagnosing: Mental Health Diagnosis, Medicalization, and the Making of Transgender Patients. *Humanity & Society*, *41*(1), 37–72. https://doi.org/10.1177/0160597615604651

Earle, S., Foley, P., Komaromy, C., & Lloyd, C. E. (2009). Health, Medicine and Surveillance in the 21st Century. *Surveillance & Society*, 6(2), 96–100. https://doi.org/10.24908/ss.v6i2.3250.

Family Educational Rights and Privacy Act 20 U.S.C. § 1232g. (1974).

Foucault, M. (1988). *Madness and civilization : a history of insanity in the Age of Reason*. Vintage Books.

Foucault, M. (1995). *Discipline and punish : the birth of the prison* (2nd Vintage books ed.). Vintage Books, a division of Random House. https://ebookcentral.proquest.com/lib/york/detail.action?docID=5336684

Grue, L., & Heiberg, A. (2006). Notes on the History of Normality – Reflections on the Work of Quetelet and Galton. *Scandinavian Journal of Disability Research*, *8*(4), 232–246. https://doi.org/10.1080/15017410600608491

Gurman, S. & Fanelli, J. (2025, September 11). Early Bulletin Said Ammunition in Kirk Shooting Engraved With Transgender, Antifacist Ideology; Some Sources Urge Caution. *The Wall Street Journal.* https://www.wsj.com/livecoverage/charlie-kirk-shot/card/ammunition-in-kirk-shooting-engraved-with-transgender-antifascist-ideology-sources-pdymd1sXXMSlVRhpvR4b

Hale, S. (2025, April 2). Motivated by Fame, the Covenant Shooter Prepared For Years Before Attack on Nashville School. *Nashville Banner.* https://nashvillebanner.com/2025/04/02/covenant-school-shooting-report/

Guest, D. (1997). *The Emergence of Social Security in Canada.* UBC Press.

Hlynsson, J. I., Skúlason, S., Andersson, G., & Carlbring, P. (2025). Why are we still using the PHQ-9? A Historical Review and Psychometric Evaluation of Measurement Invariance. *Psychiatric Quarterly*. https://doi.org/10.1007/s11126-025-10208-9

Jacobson, N. (2024, October 23). *Epidemics, Incoulation, and the Trans-Atlantic World.* History of Sciences Department, University of Wisconsin Madison.

Khúc, M. (2024). *Dear Elia: letters from the Asian American abyss*. Duke University Press. https://www.jstor.org/stable/10.2307/jj.9421069

Maclean, K. (2016). Sanity, "madness," and the academy. *The Canadian Geographer*, 60(2), 181–191. https://doi.org/10.1111/cag.12264

Marx, K. (2015). Alienated Labour. In *Working in America* (4th ed., pp. 3–9). Routledge. https://doi.org/10.4324/9781315631011-2.

Menzies, R. J., Reaume, G., & LeFrançois, B. A. (2013). *Mad matters : a critical reader in Canadian mad studies*. Canadian Scholars' Press.

Nightingale, F. (2013). *Florence Nightingale and Hospital Reform : Collected Works of Florence Nightingale, Volume 16* (L. McDonald, Ed.). Wilfrid Laurier University Press. https://doi.org/10.51644/9781554582884

Nishida, A. (2022). *Just care : messy entanglements of disability, dependency, and desire*. Temple University Press.

Pence, C. (2024). *De l'homme moyen à la population statistique: Quetelet et Galton*. Académie royale de Belgique, Classe des Lettres et des Sciences morales et politiques. https://hdl.handle.net/2078.5/214203

Piepzna-Samarasinha, L. L. (2022). *The future is disabled : prophecies, love notes, and mourning songs*. Arsenal Pulp Press.

Price, M. (2011). *Mad at school: rhetorics of mental disability and academic life.* (1st ed.). University of Michigan Press. https://doi.org/10.3998/mpub.1612837

Price, M. (2024). *Crip Spacetime: Access, Failure, and Accountability in Academic Life*. Duke University Press. https://doi.org/10.2307/jj.14638157

Pyne, R. (2026, April 3). 5-Year Waiting Period Keeps Immigrants Off Medicaid/chip, Even as States Use State-Only Funds. *Visa Verge*. https://www.visaverge.com/visarequirements/5-year-waiting-period-keeps-immigrants-off-medicaidchip-even-as-states-use-state-only-funds/

Rothman, D. J. (1971). *The Discovery of the Asylum*. Little, Brown.

Saltes, N. (2013). 'Abnormal' Bodies on the Borders of Inclusion: Biopolitics and the Paradox of Disability Surveillance. *Surveillance & Society,* 11(1/2), 55–73. https://doi.org/10.24908/ss.v11i1/2.4460

Samuels, E. (2023). Twenty-Seven Ways of Looking at Crip Autotheory. In M. Mills & R. Sanchez (Eds.), *Crip Authorship* (p. 203). NYU Press. https://doi.org/10.18574/nyu/9781479819386.003.0022

Spade, D. (2020). Mutual aid: building solidarity during this crisis (and the next). Verso.

Subramanium, S. V., Villanueva, W. R., Persaud, S., Shanouda, F., Pilling, M. D., Costa, L., Voronka, J., Pitt, K. A., & Ross, L. E. (2025). *Mind the Gaps: A survival guide for graduate students.* https://mindthegapsguide.ca/

Tafreshi, D. (2022). Adolphe Quetelet and the legacy of the "average man" in psychology. *History of Psychology, 25*(1), 34–55. https://doi.org/10.1037/hop0000202

Timotija, F. (2025, September 13). Kirk murder suspect ‘deeply indoctrinated with leftist ideology,’ Cox says. *The Hill*. https://thehill.com/homenews/state-watch/5502176-kirk-murder-suspect-leftist-cox-report/

Toledo, M. (2025). What Is a Groyper? Debunkin Rumors on Whether Charlie Kirk Shooter Tyler Robinson Was One. *IBTimes UK*. https://www.msn.com/en-gb/news/world/what-is-a-groyper-debunking-rumors-on-whether-charlie-kirk-shooter-tyler-robinson-was-one/ar-AA1MsN3t

Thompson, E. P. (1967). TIME, WORK-DISCIPLINE, AND INDUSTRIAL CAPITALISM. *Past & Present*, *38*(1), 56–97. https://doi.org/10.1093/past/38.1.56

Trent, J. W. (1994). *Inventing the feeble mind : a history of mental retardation in the United States*. University of California Press.

University of Alberta. (n.d.). *Wahkohtowin bundle* [PDF]. https://www.ualberta.ca/en/wahkohtowin/media-library/data-lists-pdfs/wahkotowin-bundle.pdf

Vaz, P., & Bruno, F. (2003). Types of Self-Surveillance: from abnormality to individuals ‘at risk.’ *Surveillance & Society,* 1(3), 272–291. https://doi.org/10.24908/ss.v1i3.3341.

Weil, J. Z. (2026, January 16). ‘A piece of chicken, a piece of broccoli’: Agriculture secretary says healthy meals cost $3—The Washington Post. *The Washington Post*. https://www.washingtonpost.com/business/2026/01/16/three-dollar-meals-rollins/

Yandell, K. (2025, October 21). RFK Jr.'s Inaccurate Claims About Tylenol, Circumcision and Autism. *FactCheck.Org*. https://www.factcheck.org/2025/10/rfk-jr-s-inaccurate-claims-about-tylenol-circumcision-and-autism/

Zdanowicz, C. (2023, March 30). Nashville shooter Audrey Hale had a 'child-like obsession with staying a child,' college classmate says. *CNN* https://www.cnn.com/2023/03/28/us/audrey-hale-nashville-school-shooting/index.html

Zuboff, S. (2015). Big other: Surveillance Capitalism and the Prospects of an Information Civilization. *Journal of Information Technology*, 30(1), 75–89. https://doi.org/10.1057/jit.2015.5.