

QUEER AND TRANS MADNESS: BIOMEDICAL AND SOCIAL
PERSPECTIVES ON MENTAL DISTRESS

MERRICK DANIEL PILLING

A DISSERTATION SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN GENDER, FEMINIST, AND WOMEN'S
STUDIES
YORK UNIVERSITY
TORONTO, ONTARIO

November 2014

©Merrick Daniel Pilling, 2014

ABSTRACT

Queer and trans people have a particularly fraught relationship to the concept of ‘mental illness’ due to the longstanding and ongoing pathologizing of gender and sexual dissidence. Lesbian, gay, bisexual, queer, and trans (LGBTQ) activists have challenged the notion that non-normative sexualities and genders are forms of ‘mental illness,’ arguing for depathologization on the basis of the healthiness of queer and trans desires, relationships, and embodiments. Yet there are troubling consequences of arguing for equity based on the assertion of mental healthiness and the disavowal of connections between notions of mental distress and LGBTQ people. Insights from mad studies suggest that this perspective can be seen as perpetuating the positioning of mental distress as a deficit as well as sanist ideologies about agency and personhood. Moreover, intersectional understandings of sexuality, gender, and disability indicate that there is a population of LGBTQ people who experience mental distress. Challenges to the dominant biomedical model of mental illness have emerged from those who emphasize social approaches. These perspectives stress the importance of social context and question the efficacy of medical strategies to fully address mental distress.

This dissertation examines the voices and viewpoints of 37 people who identify as LGBTQ and who experience mental distress in their everyday lives. Interviewed in Toronto and Winnipeg, these individuals offer distinct perspectives on biomedical and social approaches to mental distress. The first chapter reviews some of the literature in mad studies and discusses methodological decisions. The second chapter outlines some of the main critiques of the biomedical model and presents some of the social factors that played a role in participants’ experiences of mental distress. Chapter three examines

participants' encounters with mental health care practitioners, analyzing the effects of the biomedical model in practice. Chapter four draws on Canada's national mental health strategy and participants' narratives to examine the concept of recovery. Chapter five explores interview data about employment as well as scholarly work regarding 'invisible identities' to analyze the participants' workplace experiences. Overall, this dissertation uses the intersectional voices and viewpoints of LGBTQ people who experience mental distress to critique dominant understandings of 'mental illness.'

ACKNOWLEDGMENTS

This dissertation would not have been possible without the 37 people who participated as interviewees. I am profoundly grateful for their willingness to share their insights and experiences. I am also grateful to my supervisor Marc Stein, for his intellectual support, thoughtful engagement, close readings, and attention to detail. Thank you to Geoffrey Reaume for the introduction to Mad Studies in the graduate courses Mad People's History and History of Health Care Ethics, and for the support of this project as a dissertation committee member. Thanks are due to Sheila Cavanagh for her thought provoking questions and incisive critiques in her role as a dissertation committee member. Thanks are also due to the doctoral students in the Graduate Program in History and the Gender, Feminist, and Women's Studies Program who participated in Marc Stein's dissertation writing group and provided feedback on chapters two and five. The members of the dissertation examining committee, Marina Morrow, Kimberley White, and Rachel Gorman provided helpful feedback, thoughtful questions and a lively discussion at the dissertation defence. The administrative staff in the School of Gender, Sexuality and Women's Studies offered friendly support in navigating bureaucracy throughout the years. Applying to a doctoral program was made possible by the support of my undergraduate mentor, Pauline Greenhill and MA supervisor Jane Helleiner as well as friends and family. Financial support was received from the Ontario Graduate Scholarship Program and the Gender, Feminist, and Women's Studies Program at York University.

TABLE OF CONTENTS

Abstract.....	ii
Acknowledgments.....	iv
Table of Contents.....	v
Introduction.....	1
Madness.....	9
Chapter summaries.....	13
Chapter One: Mad Studies: Literature Review and Methodology.....	18
Mad studies.....	19
Historiography of madness.....	22
Contemporary critiques: Anti-psychiatry studies.....	37
Contemporary critiques: Sexuality and gender identity in the Diagnostic and Statistical Manual of Mental Disorders.....	43
Qualitative interviewing.....	52
Terminology and methodology.....	57
Recruitment and conducting interviews.....	62
Ethical research practice.....	63
Chapter Two: Making Sense of Madness: Social Approaches to Lesbian, Gay, Bisexual, Queer, and Trans Experiences of Mental Distress.....	71
Making oneself intelligible: The importance of language.....	72
The biomedical model of mental illness.....	75
Social approaches to mental distress.....	78
The biomedical model as a deficit model: Insights from disability studies.....	79
Challenging the mind/body dichotomy and embracing a more holistic approach.....	85
Resisting the pathologization of marginalized groups.....	87
Challenging the sane/insane binary.....	91
Making sense of mental distress through psychiatric diagnosis.....	94
Alternatives to diagnostic categorizing.....	107
Making sense of mental distress: Resisting individualization and acknowledging social context.....	109
Chapter Three: The Biomedical Model in Practice: Lesbian, Gay, Bisexual, Queer, And Trans Encounters With Mental Health Care Practitioners.....	120
Availability of services in Winnipeg and Toronto.....	122
Power dynamics in relationships informed by biomedicalism.....	128
“Going back to gender and sexuality 101”: Practitioner ignorance.....	133
Practitioner lack of awareness about processes of racialization and racism.....	137
Individualizing distress through pathologizing sexualities.....	140
Pathologizing sexuality: Diagnosing promiscuity.....	143
Pathologizing gender identity.....	147

Pathologizing Indigenous LGBTQ people.....	150
Biomedical methods of managing mental distress: Medication as ‘corrective’	154
Respect for agency in decision-making about psychiatric medication	158
 Chapter Four: Changing Directions or Staying the Course? Race, Gender, Sexuality, and Recovery in Canada’s Mental Health Strategy.....	167
What is mental health recovery?.....	168
‘Recovery’ in <i>Changing directions, changing lives</i>	170
Recovery in the context of ‘diversity’ and ‘disparity’: Strategic direction four.....	173
Priority 4.1: “Make improving mental health a goal when working to enhance overall living conditions and health outcomes”	175
Priority 4.2: “Improve mental health services and supports by and for immigrants, refugees, ethno-cultural and racialized groups”	177
Priority 4.5: “Address the specific mental health needs related to gender and sexual orientation”	183
Shifting the paradigm in mental health service provision.....	193
Recovery as a “collective journey”	202
 Chapter Five: (In)visibility in the Workplace: Navigating Disclosure and Intersectional Oppression at Work.....	215
The importance of employment.....	216
Employment and LGBTQ people who experience mental distress: An overview.....	218
Mental distress: An invisible disability?.....	227
The ‘invisibility’ of sexuality and gender identity	230
‘It’s personal’: Disclosing ‘private’ information in the workplace.....	237
‘It’s irrelevant’: Sexuality, gender identity, race, and mental distress as ‘neutral’	241
Sanism, authenticity and access to accommodations.....	252
Making the workplace more accessible.....	258
 Conclusion.....	264
 Bibliography.....	279
 Appendix A:	301

Queer and Trans Madness: Biomedical and Social Perspectives on Mental Distress

My mother says psychiatry saved her life. In 1983, after years of experiencing intense mental and physical distress for which no doctor could find cause or treatment, she was diagnosed with panic disorder. This condition, newly added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) III in 1980, provided my mother with the answers she had been looking for. At long last she had an explanation for the nameless force that had so profoundly interfered with her ability to function in everyday life. She had panic disorder, an illness like any other and one that could be treated with psychiatric interventions and medications. In many ways, her encounters with the mental health system contributed to the formation of my academic interest in the ways in which mental distress is understood and addressed.

Though personal and experiential, my mother's narrative reflects an ideological position espousing the biomedical model of mental illness. This model categorizes various experiences, behaviours, and thought patterns as indicative of biological deficiencies that can be scientifically evidenced and universally applied. The biomedical model of mental illness is currently predominant; indeed, as Lewis (2006) contends, it “has become so dominant that it may seem that there are no alternative models” (p. 108). It informs most forms of mental health care, including psychiatry, psychology, and social work, but extends far beyond formal medical settings into public policy, popular culture, and everyday language. Indeed, the biomedical model of mental illness underpins commonplace understandings of health and wellbeing.

In many ways, this dissertation takes a critical stance towards the biomedical model of mental illness, particularly as it pertains to lesbian, gay, bisexual, queer, and

trans (LGBTQ) people. The longstanding and ongoing pathologizing of gender and sexual dissidence means that LGBTQ people have a particularly fraught relationship to the concept of 'mental illness.' As a young person who fell outside the norm in terms of sexuality, I encountered this early on. In high school I started exploring the possibility that I could reject heterosexuality. It was the mid-1990s and the term 'queer' was quickly gaining popularity but had not yet made it into my teenage vocabulary. I made friends with other students 'like me': femme girls attracted to other girls and sometimes boys. When one of us got caught underage in a gay bar, her mother's response likely exceeded what it would have been had she been caught in a straight bar. My friend was sent to a psychiatrist, who diagnosed her with gender identity disorder (GID) based on her sexual behaviours and desires. It was recommended that she continue "treatment" with the psychiatrist for this "condition." As teenagers with little power to protest, we believed this was wrong but felt unable to do anything about it. For me, this served as an introduction to the ways that psychiatry could be used in the service of policing sexuality.

My friend's experience is not an isolated occurrence. Homosexuality was listed as a disorder in the first two versions of the DSM in 1952 and 1968, and despite its removal in 1973, gender and sexual dissidence continue to be pathologized (Carr, 2005; Sedgwick, 1993). As will be discussed in more detail in the next chapter, lesbian and gay activists who pressured the American Psychiatric Association to remove homosexuality and related diagnoses from the DSM fought to break the associations between lesbian and gay people and 'mental illness' and assert the 'healthiness' of 'same-sex' desire and relations. Trans activists have engaged in different struggles because GID diagnoses greatly influence access to the technologies of medical transition, yet the trans movement

has likewise employed the tactic of asserting the existence of ‘mentally healthy’ trans people as a means to argue for increased autonomy and depathologization (Lev, 2005; Spade, 2006; Winters, 2008).

As an adult, I found myself subjected to the same diagnosis as my high school friend, albeit under different circumstances. In 2011, while working on this dissertation, I sought access to the medical technologies of gender transition. My relatively privileged position in terms of age, whiteness, community support, and access to Canadian Union of Public Employees (CUPE) local 3903’s groundbreaking Trans Fund allowed me to minimize (though not eliminate) the extent to which I had to ‘prove’ my gender and be deemed ‘authentically’ trans by medical experts.¹ I approached the process equipped with a perspective that positioned GID as a strategic mechanism facilitating access to medical transition rather than as definitional of my sense of self.

The work that gay, lesbian, and trans activists have done in challenging the associations between mental pathology and gender and sexual dissidence have allowed myself and others to understand ourselves in a positive light and recognize that medical definitions are only a fraction of the myriad ways that we can conceptualize non-normative genders and sexualities. This work has helped us comprehend that these definitions were created by people with very superficial understandings of queer and trans lives. Yet there are also troubling consequences of arguing for equity based on the assertion of mental ‘healthiness’ and the disavowal of connections between notions of mental distress and LGBTQ people. This maneuver perpetuates the biomedical

¹CUPE 3903 is a union for teaching assistants, graduate assistants, and contract faculty at York University. During collective bargaining in 2005, trans activists in the union successfully fought for a fund for members who have financial needs related to being trans. The fund’s inaugural year was 2006/2007. For more information about the fund, how it works and what it covers see: <http://3903.cupe.ca/410-2/>

positioning of mental illness and madness as a deficit as well as sanist ideologies about incapacity, agency, and personhood. It also ignores the existence of LGBTQ people who are diagnosed with a range of other ‘mental illnesses’; the DSM-5 lists over 300 disorders that pathologize various aspects of human life and experience. One of the central questions motivating my work concerns LGBTQ people who experience mental distress or who have been deemed ‘mentally ill’ on the basis of any of the other many diagnoses in the DSM. What are the experiences of those who live at the intersections of madness and LGBTQ identities? The qualitative study that forms the basis of this dissertation presents material from 37 interviews with LGBTQ people who have experienced mental distress in two Canadian cities, Winnipeg in Manitoba and Toronto in Ontario, with the goal of capturing some of these experiences.

The question of LGBTQ people's relationship to madness is in some ways taken up by scholars who position LGBTQ people as an ‘at risk’ or ‘vulnerable’ group concerning mental health because of the widespread nature of homophobia and transphobia. There is a growing body of literature that claims there is a higher prevalence of ‘mental health problems’ amongst LGBTQ people because of discrimination and negative social attitudes about non-normative sexualities and genders (Chamberland and Saewyc, 2011; McIntyre, Daley, Rutherford, & Ross, 2011; Morrison, 2011; Rotondi, Bauer, Scanlon, Kaay, Travers & Travers, 2011; Rotondi, Bauer, Travers, Travers, Scanlon & Kaay, 2011). In this formulation, it is homophobia and transphobia that cause ‘mental illness’ or ‘mental health problems,’ rather than anything inherent in being LGBTQ. Providing empirical proof of the negative health impacts of homophobia and

transphobia serves the important function of bolstering the legitimacy and necessity of struggles to eradicate such oppression across various contexts.

The results of my study support the contention that oppression of all kinds, including homophobia, transphobia, sanism, ableism, sexism, classism, and racism, have negative effects on LGBTQ people.² Indeed, I argue throughout this dissertation that oppression can contribute to or lead to mental distress. However, this is not quite the same as the claim that LGBTQ people are more vulnerable to ‘mental disorders.’ The latter is limited in that it does not challenge the concept of ‘mental illness’ and the medicalization of distress.

Drawing on social approaches to mental distress, I question the need to medicalize experiences and behaviours that get called ‘mental illness’ and ‘mental health problems,’ not because mental illness is ‘bad,’ but because the medical model does not adequately acknowledge social contexts. I also question the efficacy of medical strategies to fully address mental distress, especially given the vexed context in which this occurs for LGBTQ people. Is it possible and desirable to rely on an ideological system that has been key in the colonization of Indigenous people and the social control of marginalized groups, including LGBTQ people, racialized people, and women? (Carr, 2005; Chunn & Menzies 1988; Harper, 1988; Hughes, 1993; Jackson, 2002; Kanani, 2011; Kanani 2012; Menzies, 2002; Menzies & Palys, 2006; Scholinski, 1997; Vermette, 1988; Winters, 2008; Yellow Bird, 2004).

² Diamond (2013) defines sanism as a term that is “widely used within the [mad] community that refers to the inequality, prejudice, and discrimination faced by people who are constructed as ‘crazy’ within dominant culture” (p. 77). Perlin (2002) attributes the first use of this term to Morton Birnbaum in 1974 (p. 684).

My main argument is therefore twofold. First, oppression that specifically affects LGBTQ people exists both within and outside the mental health system, which can be a contributing factor to mental distress along with other social factors. Second, the basis on which the whole mental health system rests merits examination. In other words, a larger question haunts this dissertation; is mental distress best understood, exclusively, primarily, or even partially, as the province of science and medicine? I do not attempt to provide a full and definitive answer to this, though I do critique biomedicalism and explore alternative ways of thinking about mental distress. This question also raises the specter of related queries such as the role of biology and genetics and the complex interplay between biological and social factors. These are important questions, though I do not attempt to engage them, as I believe they are beyond the scope of this particular study. At a time when the biomedical model is arguably firmly entrenched in many areas of academic scholarship, health care, public policy, and mainstream discourse, I believe that consideration of critiques and alternative approaches is important.

I acknowledge that these are contentious questions to explore. My mother's story is a common one; the Canadian Mental Health Association states that "one in five adult Canadians (21.3 percent) will suffer a mental disorder in their lives" (CMHA, 2014). This suggests that many are personally affected by the material realities produced by dominant understandings of mental health and illness based on their own experiences or those of family members and friends. Theoretical discussions about these issues can resonate on a deeply personal and emotional level. Challenges to biomedicalism as a way of understanding and addressing mental distress can therefore evoke strong emotional responses. Those of us with experiential connections to concepts of 'mental illness' may

have strong personal investments in the truth of the biomedical model of mental illness. As someone with a parent who identifies as having a mental illness, I understand this affective response and have experienced a range of such responses myself.

I have found in sharing my work that critiques of the ‘psy-sciences’ (Rose, 1999) can be perceived as attacks on the veracity of first-hand experiences of distress. Those who have been helped by medical strategies for addressing mental distress or who know those who have can feel as if those experiences are being invalidated, dismissed, or erased. It is important to be clear that mental distress is real and has material effects on the lives of those who experience it. It is also important to acknowledge that some find that medical strategies, including psychiatric treatment and medications, are helpful. Much like critiques of law enforcement that leave room for the possibility of well-intentioned individual police officers, critiques of biomedicalism do not necessarily preclude the existence of good psychiatrists, psychologists, and other mental health care professionals who espouse the biomedical model of mental illness. For some people, including some participants in my study, health professionals operating within a biomedical framework and psychiatric medications have been helpful and have made life more live-able. However, most of my narrators also recounted experiences that indicate that there are problems with the biomedical model, particularly for LGBTQ people. As a critique of biomedicalism, this dissertation does not attempt to present a ‘balanced’ view; participants’ problematic experiences are centred as a way of demonstrating some of the problems with this framework. This is not meant to discount the reality that some experience biomedical approaches as helpful.

The accounts of oppression within the health care system in this dissertation may also evoke skepticism in those who have limited or no lived experience of such discrimination. A recent newspaper article about racist stereotyping encountered by Indigenous women in Canada's health care system states, "When we walk into a hospital or doctor's office, we all expect our health-care providers to be respectful of us and our individual needs. Canada's aboriginal peoples - and women in particular - deserve no less" (Kielburger & Kielburger, 2013). This exemplifies typical mainstream discourse representing Canada as an accepting and safe place where 'we' will all be respected and treated as individuals rather than as representatives of maligned and marginalized groups. For those who believe in this liberal fantasy, some of the experiences of the participants in this study may evoke feelings of surprise or disbelief. For many of the narrators, however, experiences with racism, classism, ableism, sexism, homophobia, transphobia, and other kinds of oppression mean that they can not take for granted that they will always be treated with respect, both within and outside of the health care system. The refusal to believe that such things take place is part of what maintains the conditions that facilitate their existence, justifying the positioning of interventions as unnecessary or as addressing 'special needs.' In centering the participants' first-hand accounts, I argue that mental health care practitioners do not simply make 'objective' assessments of mental health; rather, the process is enculturated and therefore reflects oppressive systemic values. This disrupts the notion that all those who seek mental health care receive equal treatment and that the mental health system is equipped to address the needs of LGBTQ people. This may be an unsettling claim for some readers of this dissertation.

Madness

In the first year of my doctoral studies, my youngest cousin killed herself at the age of nineteen. As the impact of this tragedy reverberated through my family, I looked for ways to make sense of the conditions that led her to end her life. My mother's favoured explanation, that she was a victim of mental illness, left me unsatisfied. This, in part, motivated me to take Geoffrey Reaume's York University graduate course, which was titled "Mad People's History." This was my first encounter with what is now called 'mad studies,' an interdisciplinary body of work that provides an alternative to "psy-centred ways of thinking, behaving, relating, and being" (Menzies, LeFrancois, & Reaume, 2013). This course gave primacy to the voices of those with lived experience of mental distress, sidelining those usually considered the 'experts' on these matters (Reaume, 2006). There is perhaps nothing that can ever fully quiet the 'why' that remains with those who know someone who committed suicide, but this course offered a refreshing change from the biomedical narrative. My interest in mad studies grew, and it became the basis for one of my comprehensive examinations and the field in which I situate this dissertation.

When I began writing this dissertation in 2010, mad studies was not widely recognized as a field of study. This is beginning to change, as is evidenced by the publication of a special issue of *Disability Studies Quarterly* on madness and the edited collection *Mad matters: A critical reader in Canadian mad studies*, both in 2013. Mad studies is an emerging field that owes much to disability studies; indeed, it has been referred to as an "in/discipline" of disability studies (Ingram, 2008 as cited in Menzies, LeFrançois & Reaume, 2013, p. 12). Menzies, LeFrançois, and Reaume (2013) describe

mad studies as interdisciplinary, including work taking place in “health studies, sciences and medical faculties, along with departments of law, sociology, psychology, history, philosophy, education, communication, English literature, cultural studies, women and gender studies, socio-legal studies, disability studies, and social work” (p. 13). Mad studies is grounded in the knowledge of those with lived experience of psychiatrization and takes a “subversive standpoint relative to the governing paradigm of psychiatric ‘science’” (Menzies, LeFrançois, and Reaume, 2013, p. 11). As such, it lends itself well to my study, which is critical of biomedicalism and gives primacy to first person accounts of the lived experiences of LGBTQ people who experience mental distress.

Lesbian and gay studies, queer studies, and trans studies are also central to my study. As I argue in chapter one, some academic work in these areas can be seen as part of mad studies. Many scholars in these fields explore the intersections between knowledge production and mental ‘pathology’ as it pertains to sexual and gender dissidence (Bayer, 1981; Butler, 2004; Carr, 2005; Irvine, 2005; Lev, 2005; Minton, 2002; Scholinsky, 1997; Sedgwick, 1993; Spade, 2006). Likewise, scholars focusing on processes of racialization and racism show how these are imbricated in conceptualizations of mental health and illness (Baskin, 2007; Bennett, Blackstock, & De La Ronde, 2005; Chunn & Menzies 1988; de Leeuw, Greenwood, and Cameron, 2010; Fernando, 2010; Harper, 1988; Hughes, 1993; Jackson, 2002; Kanani, 2011; Kanani 2012; Menzies, 2002; Menzies & Palys, 2006; Vermette, 1988; Yellow Bird, 2004). As a nascent field, mad studies can learn from critiques of disability studies that point to the importance of taking up issues of race and racism (Bell, 2006; Bell, 2011; Bolaki, 2011; Broeck & Davis, 2011; Gorman, 2013; Jarman, 2011; Mollow, 2006; Tam, 2013).

One way of keeping social justice approaches to race, gender identity, sexuality, and other forms of social difference at the forefront of analysis is to employ an intersectional approach. Mad studies is particularly well-positioned to take up intersectionality, and as Menzies, LeFrancois, and Reaume (2013) contend, scholars in mad studies have begun to do just that (pp. 16-17). Rossiter and Morrow (2011) argue that it is “the dominance of a biomedical paradigm” that has served as an obstacle to intersectional analyses in ‘mental health’ research (p. 333). The positioning of ‘mental illness’ as an measurable ‘disease’ that can be objectively assessed and universally applied and the use of positivist approaches that reify racial difference do not serve the interests of intersectional and social justice-based approaches (Rossiter & Morrow, 2011, p. 333). Mad studies, in its rejection of biomedical approaches, is well suited to my study, which uses an intersectional approach to understand the lives of LGBTQ people who experience mental distress.

As indicated by its name, mad studies rejects the language of biomedicalism and makes use of alternative language and terminology. Throughout this dissertation I employ two such terms: ‘mental distress’ and ‘madness.’ Tew (2011) contends that “perhaps more than in any other field of health and social care, language relating to mental health issues is contested and contentious” (p. 4). Choices regarding language and naming are critically important not only because they are indicative of an ideological stance, but because of the violence that can be enacted through labelling. As Price (2011) argues, “the problem of naming...acquires a particular urgency when considered in the context of disabilities of the mind, for often the very terms used to name persons with mental disabilities have explicitly foreclosed our status *as* persons” (p.9).

Psychiatric survivor activists and scholars who critique the biomedical model suggest that we refuse to use medical language such as ‘mental illness’ (Boyle, 2011; Burstow, 2013; Tew, 2011). Burstow (2013) contends that when this language is used, “we are performing our designated role in the work of psychiatry...we are activating it” (p. 82). ‘Mental distress’ has been proposed as an alternative, because unlike the term ‘mental illness,’ it does not “do violence to people’s identities and aspirations” and it “does not imply illness, incapacity, or inferiority” (Tew, 2011, p. 5). Likewise, ‘madness’ has been politicized by those who resist the medicalization of distress with the goal of “reclaiming disparaged identities and restoring dignity and pride to difference” (Menzies, LeFrançois & Reaume, 2013, p. 10). ‘Madness’ also captures a “broad historical sweep” and acknowledges that biomedicalism is just one of many ways in which such matters have been understood (Price, 2011, p. 10).

In addition to referring to ‘madness’ and ‘mental distress,’ I also make use of the phrase ‘mental health,’ as it has been institutionalized as an umbrella term to describe mental well-being, various states of mind, and what are often understood as ‘disorders’ (for example, by the Canadian Mental Health Association and the Mental Health Commission of Canada). Because of this, when the participants in my study and I were talking, we often spoke in terms of ‘mental health’; this language structured their everyday lives, especially in health care settings but also at work and in everyday practices. I therefore also use this term as an acknowledgement of the current context in which madness is understood and thus the ways in which the research participants are positioned. ‘Mental health’ is the predominant framework available to them to make sense of themselves. However, I make use of this term carefully and selectively. As other

scholars have argued, ‘mental health’ is no less complicit with biomedical ideology than the term ‘mental illness’ (Boyle, 2011; Burstow, 2013).

Chapter summaries

This dissertation begins with a literature review that locates this work in mad studies. I present a historiography of madness with a focus on the racialized, sexualized, and gendered character of knowledge production in this area. This demonstrates how ideas about madness have shifted over time and how elite discourses have influenced predominant ideologies about madness. I then review more contemporary work that is critical of biomedical approaches to mental distress, focusing on the impact of biomedical frameworks on those deemed ‘mentally ill.’ I draw on anti-psychiatry studies, lesbian and gay studies, queer studies, and trans studies, arguing that work from all of these fields can be seen as contributing to mad studies. I contend that these bodies of literature have much to say to one another, in that anti-psychiatry studies tends to overlook the perspectives of racialized, queer, and trans people, while lesbian and gay studies, queer studies, and trans studies could do more to consider the connections between LGBTQ lives and experiences of mental distress. This chapter concludes with a discussion of some of the key methodological decisions that shaped this project.

In chapter two I challenge biomedicalism as the best way to make sense of LGBTQ experiences of madness and present social approaches to mental distress as another way of making these experiences intelligible. While the biomedical model has become so predominant that it is difficult to conceptualize experiences of mental distress through any other lens, the participants’ narratives clearly demonstrate some of the problems with biomedicalism and point to the benefits of using frameworks that take

social context into account. I show that an individualistic model like biomedicalism is especially problematic for marginalized groups, as it erases or downplays discrimination and structural disadvantage while also serving to perpetuate such oppression.

In chapter three I present participants' experiences with health care practitioners in order to examine the biomedical model in practice. I argue that the power relations embedded in practice based on biomedicalism create inequitable and sometimes damaging relationships between service providers and participants. Further, practitioners demonstrate a striking lack of knowledge about LGBTQ and racialized cultures, relationships, identities, and experiences, often resulting in inadequate care at best. Participant narratives show that many service providers continue to pathologize LGBTQ people through various means, including the positioning of nonnormative sexual and gendered behaviours, desires, and practices as deviant, the reliance on diagnostic criterion regarding 'promiscuous' behaviour, and the use of mental health systems and child protective services as tools of (neo)colonial regulation. I argue that this challenges the notion that mental health care practitioners informed by biomedicalism perform objective assessments of participants' mental health and points to clearly subjective judgments and discriminatory beliefs underpinning biomedical practice.

In chapter four, I examine the currently popular concept of recovery from 'mental illness.' Canada's first national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, published in May 2012, employs 'recovery' as a key concept in envisioning change in the Canadian mental health system. Drawing on the sections of the strategy document that focus on race, gender, and sexuality, I take a close look at how the state interprets the conditions that lead to

recovery from ‘mental illness’ for LGBTQ people. I argue that *Changing Directions*, *Changing Lives* makes a departure from a strictly biomedical view of ‘mental illness,’ but falls short of advancing a strong structural understanding of how homophobia, transphobia, racism and other forms of oppression shape LGBTQ experiences of mental distress, access to services, and recovery. I contrast this with participant narratives about the conditions that facilitate being able to cope with mental distress, arguing that there is a need to shift the focus more radically toward the social and structural factors that influence ‘recovery.’

In the final chapter, I present participants’ experiences with employment in order to examine how mainstream conceptions of ‘mental illness’ affect their work lives. I argue that some of the basic tenets of the biomedical model of mental illness are widely accepted and position those deemed ‘mentally ill’ as unfit or less preferable for many jobs. Drawing on scholarly work about ‘invisible’ identities, I discuss the difficulties this creates for participants who must decide whether to disclose information about experiences of mental distress, as well as their sexualities and gender identities. I argue that such decisions are particularly pressing and high risk at work, given the economic stakes, the effects on health and well-being, and the prevalence of discriminatory beliefs and practices in the workforce. The participants’ narratives demonstrate that race, gender, sexuality, and experiences of mental distress are not ‘private’ or neutral social differences in the workplace and in fact structure many aspects of their work lives, including obtaining and retaining work, evaluations of job performance, and access to workplace accommodations.

This study will be of interest to scholars working in a wide range of fields, particularly those with a focus on social justice and marginalization and those working in mad studies, disability studies, lesbian and gay studies, queer studies, trans studies, women's and gender studies, social justice and equity studies, and critical race studies. It is also relevant to fields with an investment in the biomedical model of mental illness, including psychology, psychiatry, and social work. I believe that this study makes a contribution to all of these fields in that I take a rare approach that is intersectional, qualitative, social scientific, and oriented to social justice, all of which is done in ways that give primacy to first-person accounts of LGBTQ people who experience mental distress.

The matters I examine in this dissertation are timely. The work of the MHCC has created “an important political moment in Canadian history for discussing and debating how best to meet the diverse mental health needs of the population” (Rossiter & Morrow, 2011, p. 314). With more attention being paid to the ‘mental health’ of Canadians, there may be opportunities to influence the ways in which LGBTQ people are understood in relation to concepts of ‘mental health and illness.’ LGBTQ and mad studies scholars and activists must employ critical perspectives that question the discourses that have been mobilized both within the mainstream and by LGBTQ and mad movements. We must exercise caution in relation to mainstream discourses perpetuating biomedical approaches, as well as those employed by LGBTQ activists in the effort to distance LGBTQ people from notions of illness and pathology. Mental distress is a critically important issue for LGBTQ communities, and the ways in which this gets taken up will have serious practical impacts in terms of advocating for and creating services that will best serve

LGBTQ people. Strong alliances between LGBTQ and mad activists and a commitment to anti-racism could create positive changes. Further, the ways in which mental distress is understood has a profound impact on how we make sense of our experiences, but also our very sense of who we are. How mental distress is understood and addressed can sometimes mean the difference between life and death.

Chapter One: Mad Studies: Literature Review and Methodology

In this chapter I locate this dissertation in mad studies, review some of the relevant scholarly literature, and describe the methodology for this project. I begin with a discussion of mad studies before proceeding with a critical review of some of the historical literature that positions madness as a social construct, focusing on the racialized, sexualized, and gendered character of knowledge production about madness. I then consider more contemporary literature from anti-psychiatry studies that positions psychiatry as a disciplinary force that regulates social behaviour through the creation of the categories 'sane' and 'insane.' I argue that much of this work offers important insights about psychiatry, but does not specifically address race, sexuality, and gender. I therefore review the work of gay and lesbian studies, queer studies, and trans studies scholars to show how psychiatry has specifically targeted those who are non-normatively sexualized and gendered, often through the psychiatric diagnoses of homosexuality and gender identity disorder. This literature shows how the sexualities and gender identities of lesbian, gay, bisexual, queer, and trans (LGBTQ) people have been constructed as pathological. However, most of this work maintains a narrow focus on the specific diagnoses that most obviously affect LGBTQ people, such as gender identity disorder. Most of this literature also does not explicitly address race and racism.

In the second half of this chapter I discuss the methodological choices I made in creating and carrying out this project. This includes a discussion of my decision to use qualitative interviewing as a method, the recruitment of participants and the process of conducting interviews, my choices about terminology, and the specific ethical considerations that have been relevant to my project.

Mad studies

Following LeFrançois, Menzies, and Reaume (2013), I use mad studies to refer to an interdisciplinary field of study that critiques current conceptions of mental illness as a biological condition that can be scientifically evidenced and universally applied. Mad studies is emergent and loosely defined, but LeFrançois, Menzies, and Reaume (2013) have identified ten common themes that characterize the field. These include the notion that mad studies is a “project of inquiry, knowledge production, and political action” that critiques the ‘psy sciences’ and is invested in social change (LeFrançois, Menzies, and Reaume 2013, p. 13). It is interdisciplinary and “multi-vocal” in that it includes “people from every conceivable social position and walk of life” (LeFrançois, Menzies, and Reaume 2013, p.13). As such, mad studies is not solely an academic project and it takes up any number of theoretical and practical approaches and methodologies. It is grounded in the lives and experiences of mad people and is very much rooted in the “grassroots advocacy of psychiatrized people” (LeFrançois, Menzies, and Reaume 2013, p.14). It is not proscriptive and includes perspectives from groups who define themselves differently in terms of their relationship to madness and mental health and have varying perspectives on psychiatry and the mental health system.

In addition, “mad studies is an exercise in critical pedagogy” and knowledge production that employs “subjugated knowledge” to challenge prevailing ideas about ‘mental illness’ and the psy sciences (LeFrançois, Menzies, and Reaume 2013, p. 14). It is engaged in “historical memory work” in order to show how ideas about madness shift over time and to place “mad people at the centre of their own narratives” and demonstrate they have existed across time (LeFrançois, Menzies, and Reaume 2013, p. 15). It pays

special attention to structural analyses of power relations and is especially amenable to intersectional approaches. Mad studies aims to massively restructure the “‘mental health’ industry”, indicating an intention to bridge “the long-standing divide between scholarship and activism” (LeFrançois, Menzies, and Reaume 2013, p. 17). Finally, mad studies aims to remain grounded in, and stay relevant to, “the immediate practicalities of everyday human struggle” of those who are currently interacting with biomedical approaches to mental illness and the mental health system (LeFrançois, Menzies, and Reaume 2013, p. 17).

As a nascent and interdisciplinary field, mad studies has boundaries that are not firmly defined. Some of the work I include in this chapter is also part of lesbian and gay studies, queer studies, trans studies, and critical race studies. I believe this work can be seen as part of mad studies. LeFrançois, Menzies and Reaume (2013) characterize mad studies as inclusive of work taking place in “health studies, sciences and medical faculties, along with departments of law, sociology, psychology, history, philosophy, education, communication, English literature, cultural studies, women and gender studies, socio-legal studies, disability studies, and social work” (p. 13). While recognizing that these authors certainly do not intend this list to be exhaustive, I believe it is particularly important to explicitly name scholarship in lesbian and gay studies, queer studies, trans studies, and critical race studies as part of mad studies. These areas of study make significant contributions to mad studies, in no small part because the psy-sciences have long been heavily implicated in the social control and marginalization of LGBTQ and racialized groups.

The larger goal of this literature review is to provide a context for my own study of LGBTQ people who experience mental distress. Mad studies is amenable to my own study in many ways. These include the focus on challenging the biomedical model of mental illness, the value placed on first-person accounts of lived experience and social justice perspectives, the attention to structural oppression, and the use of intersectional approaches. I use the existing literature to position madness as an ever-changing, historically and culturally specific social construct that has great power over people's lives. I also use this literature to show that there is a need for intersectional social research that specifically explores the experiences of LGBTQ people regarding mental distress. My study examines the impact of the biomedical model of mental illness on the lives of LGBTQ people who experience mental distress. Some of the larger questions structuring my research are as follows: What do LGBTQ people have to say about their identities and experiences concerning mental distress? How do LGBTQ people navigate dominant understandings of mental health in their everyday lives? How does the biomedical model of mental illness impact LGBTQ people and how might social approaches offer another way of making experiences of mental distress intelligible? What is the role of processes of racialization and racism in shaping these experiences? My research attempts to address some of the questions that are left unanswered in the currently available literature.

Before proceeding with the review, it is important to note that the existing literature on madness (both historical and contemporary) often reflects a singular or dual focus, in that authors tend to focus on either race or sexuality and gender. There are few sources that analyze how these are mutually constituted. This is not unusual; it is, in fact,

typical of many bodies of work, including research on health inequities and mental health disparities (Dhamoon & Hankivsky, 2011; Rossiter & Morrow, 2011). While I have attempted to conceptualize the literature in a holistic manner, this division between race and gender and sexuality in the existing literature is reflected in my review.

Historiography of madness

Perhaps most famously, Foucault (1961) points to how conceptions of madness shift over time and asks questions about how the mad are differentiated from the sane and what purposes these distinctions serve. In *History of Madness*, he constructs a history of how madness has been understood in the West from the 16th century to the 19th century, arguing that during this period several shifts took place in how madness was conceptualized and thus how the mad were treated. He contends that with the decline of leprosy at the end of the 16th century, the mad became the despised ‘other,’ a figure previously embodied by the leper. At this time the poor, the criminal, and the mad were socially excluded, as the leper had been in earlier periods (Foucault, 1961, p. 6).

According to Foucault (1961), during the 17th century madness was increasingly understood as the opposite of reason and a source of shame; in this period the “great confinement” or the mass incarceration of the mad began (p. 62). However, the mad were not entirely hidden away in these institutions; they were put on display for money, as were nonhuman animals. This established new boundaries between madness and sanity, as “madness had become a thing to be observed, no longer the monster within, but an animal moved by strange mechanisms, more beast than man, where all humanity had long since disappeared” (Foucault, 1961, p. 145). Foucault argues that madness was not yet understood in a medical or correctional context; rather it was seen as a departure from

reason and an entry into an animal-like state. The way to tame animality was thought to be through physical discipline and the mad were therefore treated inhumanely (Foucault, 1961, p. 149). Foucault claims that this age of confinement lasted until the end of the 18th century, when under the purview of medicine and psychiatry madness was increasingly conceptualized as mental illness. Mental illness became positioned as a scientifically evidenced disease, something that could be managed through medical expertise. Medical strategies and ‘cures’ became a new way of exerting control over those deemed mad. For Foucault, the medicalization of madness does not indicate the discovery of an objective truth. Rather, his historical work shows that madness is a social product and a historical construct.

Covering a longer time span and providing more specific details, Porter (2002) offers a history of how madness has been understood in Western culture from the Greek philosophers of the 4th and 5th centuries BCE to the rise of psychiatry in the 20th century. In *Madness: A Brief History*, he seeks to identify who has been deemed mad, what has been considered the root of madness, and how the mad have been treated over the course of this period. He argues that the ideologies through which madness and the mad have been made intelligible have shifted over time from Christianity, through humanism, to psychology and psychiatry.

For example, he argues that for many centuries, supernatural and religious explanations of madness held sway. Those deemed mad were thought to be possessed by demons and plagued by sins, and thus religious officials were considered the most appropriate people to deal with the mad (Porter, 2002, p. 19). He contends that a critical shift in thinking occurred with Descartes, as Cartesian dualism defined the mind as

inherently rational, positioning insanity as originating in the body. Thus madness came under the purview of medicine. As Porter (2002) states, “Safely somatized...[madness] could no longer be regarded as diabolical in origin...and became unambiguously a legitimate object of philosophical and medical inquiry” (p. 58). He argues that 17th century philosophers secularized madness, positioning it as a form of irrationality and opening the door for psychological methods, suggesting the possibility for ‘correction’ through medicine. The 20th century saw the rise of psychiatric, scientific, and related paradigms regarding mental illness. According to Porter, the development of psychodynamics, psychoanalysis, and psychopharmacology blurred the boundary between the insane and the sane, in that modern approaches suggest that ‘mental illness’ is “part of normal variability” as opposed to affecting a select few (p. 208). Porter believes that this led to deinstitutionalization and the move toward out-patient and community care, as well as the proliferation of psychiatric diagnoses as detailed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which was first published in 1952.

Foucault (1961) and Porter (2002) provide the historical context necessary for conceptualizing madness as a social construct. They show that the medicalization of madness is a relatively recent phenomenon in a long history of frameworks for understanding madness. However, these works by Foucault and Porter do not consider how Western knowledge production has long been steeped in racial hierarchy. As Young (1995) details in *Colonial Desire: Hybridity in Theory, Culture and Race*, European knowledge producers used the concept of civilization as a tool of measurement to determine racial inferiority and justify colonization. As he states, “racial hierarchy was

established on the basis of a cultural pecking order, with those who had most civilization at the top, and those who were considered to have none – ‘primitives’ - at the bottom” (Young, 1995, p. 95). As Young notes, race and racism became elemental to all academic disciplines and played critical roles in defining the Western self. As he states, race “became one of the major organizing axioms of knowledge in general,” and “racist assumptions remained fundamental to the knowledge of the West and to the Western sense of self” (Young, 1995, p. 93). It is therefore important to consider how constructions of madness draw on racist ideologies and how racism influences historical and contemporary understandings of madness and mental illness. As will become evident below, the racialized character of concepts such as ‘primitive’ and ‘civilized’ that Young describes are particularly relevant to the history of knowledge production about madness.

For example, Fernando (2010) argues that ideas about race and civilization informed psychiatric knowledge production as it was first being generated in the mid-nineteenth century (p. 61). He shows that white Europeans and Americans were seen as ‘civilized,’ while racialized people such as “Eskimos, Chinese, Egyptians and American blacks” were seen as ‘uncivilized’ and ‘primitive’ (p. 61). Nineteenth century anthropological and sociological scholars such as Charles Darwin, Herbert Spencer, and Francis Galton theorized that racialized people were at a lesser stage of evolutionary development than white people (Fernando, 2010, p. 61-62). Fernando (2010) contends that “these ideas were taken on board very easily and naturally by psychiatry and western psychology” and continues to inform present day thought (p. 62).

Further, racist ideologies have informed various aspects of psychiatric practice, including that of diagnosis (Fernando, 2010, p. 67). Historical psychiatric diagnoses such

as dysaesthesia aethiopis during the era of slavery posited that freed slaves would develop a ‘condition’ that would cause them to destroy property and create havoc while also becoming unable to feel pain when punished (Fernando, 2010, p. 67). Likewise, drapetomania was a psychiatric ‘condition’ that would cause slaves to run away (Fernando, 2010, p. 67). Fernando (2010) argues that current diagnoses, while less obviously racist, are still shaped by ideas about “racial inferiority” (p. 68). For example, contemporary dominant discourses that position black people as violent, dangerous, inferior, and alien may contribute to more black people being diagnosed with schizophrenia, a condition that is “linked” to “alieness” (Fernando, 2010, p. 68). Furthermore, racism affects the diagnostic process for psychiatric conditions in many ways, including “during the recognition and evaluation of symptoms...in their assessment for the purpose of illness recognition; and in making the decision on the propriety of designating illness” (Fernando, 2010, p. 69). As just one example, black people who talk about racism may be perceived as ‘paranoid’ if racism is not understood “as a real threat to black people” (Fernando, 2010, p. 69).

Indeed, many scholars have argued that mental health diagnoses are racialized and have been used to pathologize and control black people (Gilman, 1985; Hughes, 1993; Jackson, 2002; Metzl, 2009; Waldron, 2002). One important historical work to consider the links between blackness, madness, and racism is Gilman’s (1985) *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness*. Gilman does a representational analysis of texts from the Middle Ages to the 20th century to examine stereotyping of the ‘other’ in Western society. In the chapter “On the nexus of blackness and madness,” he contends that there is a longstanding association of blackness with illness and pathology

in Western culture. He points to the ways in which blackness has long been linked to wildness and madness, citing examples from such varied sources as the Judeo-Christian Bible, Greek medicine, and the work of Mark Twain. Gilman provides historical context for his textual analysis by outlining how this association has been used to oppress black people through the creation of racist psychiatric diagnoses. Like Fernando (2010), he points to diagnoses such as drapetomania as evidence of how psychiatry was used to oppress black people. As he states, “manifestations of the blacks’ rejection of the institution of slavery were fitted into the medical model of insanity” (Gilman, 1985, p. 138).

Gilman (1985) also considers how Jewish people have been seen as physically and mentally ill. He argues that Jewish people were thought to be biologically predisposed to insanity, and those who fought for emancipation in the 18th century were seen as providing evidence of their madness (Gilman, 1985, p. 162). Gilman argues that throughout the 18th, 19th, and early 20th centuries Jewish people were constructed by European doctors as less ‘civilized’ due to their supposedly ‘primitive’ sexual practices, which were said to result in degeneration and madness (Gilman, 1985, p. 159). Gilman’s description of the theoretical linkage of racialization with sexual practices points to the importance of conceptualizing the connections between race and sexuality in the production of knowledge about madness and mental illness.

Psychiatry has also played a role in creating and maintaining stereotypes about Indigenous people (Kanani 2011; Menzies & Palys, 2002; Waldram, 2004). Waldram (2004) makes an important contribution to understanding the role of race and racism in the history of knowledge production about mental health and Indigenous people. *Revenge*

Of The Windigo is a historiography of mental health research concerning Aboriginal people in Canada and the United States. Waldram examines knowledge production about Aboriginal mental health in anthropology, psychology, and psychiatry in order to critique problematic prevailing understandings of Aboriginal people in these disciplines. Under the guise of objective science, non-Aboriginal scholars have constructed Aboriginal people and culture as homogenous and static, making essentializing generalizations that ignore individual and cultural differences. He argues that notions of Aboriginal mental health draw heavily on a 'primitivist discourse.' This discourse positions Aboriginal people and culture as inferior and underdeveloped, yet also "utopian," in that they are depicted as "uncontaminated by the pollutants of civilization" (Waldram, 2004, p. 10). Waldram concludes that scholars have generated a large volume of research about Aboriginal mental health and capabilities using faulty methodologies and problematic assumptions. As he states, "The science upon which portraits of aboriginal mental health have been constructed represents a proverbial house of cards, and a close look at this construction reveals just how tenuous our scientific knowledge is in these areas" (Waldram, 2004, p. 317-318). Waldram argues that psychology and psychiatry are particularly resistant to acknowledging the racism inherent in their theorizing, possibly due to the deeply positivist character of these disciplines.

Some scholars have shown that racist knowledge production about mental health created and legitimized a high level of incarceration of racialized people in psychiatric institutions and racist, violent treatment in these facilities (Chunn & Menzies 1988; Harper, 1988; Hughes, 1993; Jackson, 2002; Kanani, 2011; Menzies, 2002; Menzies & Palys, 2006; Yellow Bird, 2004; Vermette, 1988). For example, Yellow Bird (2004)

recounts the treatment of Indigenous people in the Hiawatha Asylum for Insane Indians outside Canton, South Dakota, from 1902 to 1933. Indigenous people were often incarcerated indefinitely in the asylum for resisting racist practices and once there were treated inhumanely. Such inhumane treatment included locking some inmates in their rooms for up to three years and the straightjacketing and chaining of children. As Kanani (2011) argues, this use of psychiatric institutions in the social control of Indigenous people in Canada and the United States is done in the service of colonization (p. 7). As she states, “by regulating Indigenous people through psychiatric institutions (among other forms of regulation such as penal systems and residential schools), settler societies have been able to permanently subordinate Indigenous people and ensure the transfer of Indigenous land to colonial governments” (Kanani, 2011, p. 7).

The literature described above makes important contributions to the positioning of madness as a racialized social construct. There is still, however, a lack of scholarship that makes connections between race, racism, and madness (Fearnley, 2008; Kanani, 2011). As Fearnley (2008) argues, many scholars still deny the importance of race in shaping this body of knowledge or fail to consider it at all. As he states, race is “commonly held by scholars to have had little to no effect upon the key concepts and practices of psychiatry” (Fearnley, 2008, p. 246). As will be seen later on in this chapter, this limited attention to race and racism carries over into some of the contemporary critiques of psychiatry and current understandings of mental illness.

Also important to the historiography of madness is the history of sexual and gender identity categories. In the nineteenth century sexological theories constructed ‘same-sex’ desire and ‘cross-gender’ characteristics as physical and mental disease,

arguably laying the groundwork for the psychiatric diagnoses of homosexuality and gender identity disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Sexological texts such as Krafft-Ebing's *Psychopathia Sexualis* (1886) and Ellis's *Sexual Inversion* (1900) are what Somerville (2000) refers to as "hybrid texts," combining theory from "comparative anatomy, with its procedures of bodily measurement, and the nascent techniques of psychology, with its focus on mental development" (p. 19).

As will be discussed, these categorizations were constructed by sexologists as forms of mental and physical pathology and are thus key in understanding current conceptualizations and intersections of madness, sexuality, and gender. The next section outlines this history, focusing on work that uses a more intersectional approach that also considers the role of race and racism (and to a lesser extent class) in the construction of these theories.

Sexology was developed in Europe and North America in the late nineteenth century. During this period sexuality increasingly came under the purview of medicine and sexologists seeking to taxonomize human sexual desires and behaviours constructed new pathological sexual categories such as "the homosexual, pervert, sadist, masochist, and frigid woman" (Bland and Doan, 1998, p. 2). Following Foucault's (1976) *History of Sexuality*, which traces the rise of the belief that sexual acts and behaviours are indicative of a certain type of person, many scholars have analyzed sexology to explore this. For example, Weeks (1985) argues that under the guise of objective science, sexologists constructed sexuality as the product of nature and created "an elaborate technology of control" (p. 63). Certain sexual practices were defined as pathological and as indicative

of an underlying perverse nature. As Felski (1998) also claims, “Sexuality was no longer simply a question of particular acts, but was expressed in appearance, personality and even bodily structure” (p. 4).

Terry’s (1999) work describes how American theories of homosexuality have shifted from the late 19th century to the late 20th century. Drawing on Foucault’s theoretical positioning of sexuality as “an especially dense transfer point” for power and knowledge, Terry employs discourse analysis to examine how scientists and doctors attempted to “maintain social and sexual order” through delineating ‘normal’ and ‘abnormal’ sexualities (Terry, 1999, p. 6). Terry argues that from 1880 to 1920 American medical authorities medicalized homosexuality through labeling it as insanity. She details how physicians construed anything outside of “heterosexual monogamous matrimony” as “sex perversion” (Terry, 1999, p. 77). These ‘perversions’ were considered hereditary and thought to manifest themselves in both physicality and “lunacy” (Terry, 1999, p. 77).

Terry (1999) contends that this ‘American obsession’ with homosexuality was based in anxiety about the challenge it posed to social and biological distinctions between genders and sexes. As she states,

First, inversion signaled the alarming effacement of gender distinctions upon which social order (i.e., male dominance) had been based. And, secondly, homosexuality further affronted the two-sex system according to which men and women, as opposites, were thought to be naturally attracted to one another (Terry, 1999, p. 78)

One of few scholars to acknowledge the racialized and classed aspects of these theories, Terry also argues that homosexuality was seen as a threat to social divisions between

racism and classes (Terry, 1999, p. 78). Anxieties about modernity, city living, and the resulting interactions between diverse urban populations were reflected in medical theories that posited that reproductive interracial sexual relations would lead to sexual perversion in offspring (Terry, 1999, p. 88). Homosexuality was also thought to exist mainly amongst working class people, who were characterized as morally 'primitive' and unable to control themselves sexually (Terry, 1999, p. 116). Likewise, the upper classes were believed to be susceptible to homosexuality due to their decadent, lascivious lifestyles. Thus physicians "were able to underscore a larger segregationist perspective that regarded the blurring of classes, races, and sex roles as inimical to the nation" (Terry, 1999, p. 116). Terry shows how these racist and classist understandings of homosexuality portrayed homosexual people of colour and poor people as inherently inferior and thus these groups were most negatively affected by the resulting campaigns against homosexuality.

As Somerville (2000) points out, academic work tends to treat the history of race and sexuality as separate and parallel rather than examining the ways in which these histories are in fact entwined. She argues that struggles over the meaning and creation of sexual identity categories occurred at the same time as efforts to define racial categories and that these concurrent struggles were not simply parallel but were in fact enmeshed. As she states, "negotiations of the color line... shaped and were shaped by the emergence of notions of sexual identity and the corresponding epistemological uncertainties surrounding them" (Somerville, 2000, p. 3).

Somerville's (2000) analysis of late 19th century and early 20th century American medical literature written by physicians, sexologists, and psychiatrists shows that theories

of sexuality depended on and made use of racial ideologies. For example, she points to the presence of scientific racism in the works of Krafft-Ebing and Ellis, arguing that the methodologies of racial science provided a model for these sexologists to use in assessing 'sexual inversion.' Racial scientists and sexologists also demonstrated gender-related apprehension, focusing on women's bodies as sites of racial and sexual 'abnormalities.' While race scientists focused on the genitalia and reproductive characteristics of African women as markers of racial difference, sexologists saw the bodies of 'female inverts' as the "visual key to ranking bodies according to norms of sexuality" (Somerville, 2000, p. 27).

Sexology also reflected the ideologies of eugenics and white supremacy in that the pathologizing of homosexuality was seen by sexologists as a form of 'degeneracy,' a concept drawn directly from eugenicist theories. Somerville (2000) demonstrates that sexologists' concerns about "mixed bodies" (i.e. 'inverts' and 'intermediate sexes') deployed models already in existence in racial science for pathologizing "biracial" bodies or "racial hybrids" as examples of the 'degeneration' that took place when 'racial purity' was not maintained (p. 32). Furthermore, Somerville (2000) argues that sexology made use of psychological theories present in racial science in order to cast homosexual desire as a form of 'perversion.' As she states, "interracial and same-sex sexuality became analogous within later conceptions of sexual object choice" (Somerville, 2000, p. 37).

Feminist theorists have also made important contributions to the positioning of madness as a social construct. Many feminist scholars have noted that women have long been more likely than men to be deemed mad (Busfield, 1996; Chesler, 1972 Ehrenreich & English, 1978; Lunbeck, 1994; Showalter, 1985; Smith & David, 1975; Smith-

Rosenberg, 1985; Ussher, 1992; Ussher, 2011). Feminists have sought to explain this phenomenon through an examination of the role of patriarchy, misogyny, and sexism in shaping historical and current understandings of madness.

Chesler's (1972) groundbreaking *Women and Madness* argues that women raised in patriarchal cultures develop traits and behaviours such as "self-sacrifice, masochism, reproductive narcissism, compassionate 'maternity,' dependency, sexual timidity and unhappiness, and father-worship," which are in turn pathologized as madness (p. xxi). Chesler bases her arguments on a wide range of materials including 19th century case histories of psychiatrized women, contemporary clinical theories and practices, statistical data from the 1950s and 1960s concerning mental illness, and sixty interviews she conducted with women about their experiences with mental health systems in England and America from 1945 to 1971. She concludes that madness has long served as a means of patriarchal social control and many women have been exploited and abused in the name of 'treatment.'

Following Chesler, Showalter (1985) contends that madness is feminized. She shows how social and medical representations of madness are deeply enculturated with gendered associations that place women "on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind" (p. 4). She examines British social and medical texts from 1830 to 1980 to show how psychiatric discourse perpetuates madness as a "female malady" that serves to regulate and control women (Showalter, 1985 p. 5). Similarly, Ussher (1992) argues that madness is deeply gendered and informed by patriarchy, sexism, and misogyny. She contends that madness 'others' women in society and "positions women as ill, as outside, as pathological, as

somehow second-rate – the second sex” (Ussher, 1992, p. 11). Ussher employs a Foucauldian discourse analysis to show how “discursive practices which create the concept of madness” keep women in a subordinate and oppressed position (Ussher, 1992, p.14).

Some feminists have looked at specific diagnoses in order to show how madness is gendered and used to oppress women. Ehrenreich and English (1978) argue that nineteenth century medicine constructed women as “innately sick” due to their reproductive organs, supposedly predisposing them to a life of illness and disability of various sorts (p. 147). Hysteria, a nineteenth century disorder characterized by loud fits of crying, laughing, and convulsions, is perhaps the quintessential example of this view. Hysteria was a highly gendered diagnosis, seen as affecting primarily women of the middle and upper classes (Ehrenreich and English, 1978, p. 153). Smith-Rosenberg (1985) notes that the symptoms of hysteria overlapped with the characteristics expected of normative femininity in Victorian society; “dependency, fragility, emotionality, narcissism” (p. 207). She analyzes hysteria as the only social role available to women who were unhappy with the demands of family life in a time when women were required to devote themselves whole-heartedly to serving the needs of their husbands and children. Acquiring hysteria offered women a partial escape from these duties, though “at the cost of pain, disability, and an intensification of woman’s traditional passivity and dependence” (Smith-Rosenberg, 1985, p. 207). Hysteria was also a way of pathologizing and infantilizing women, who were often seen as immature malingerers by hostile and sometimes sexually exploitative physicians (Ehrenreich & English, 1978, p. 147).³

³ Sigmund Freud’s talking therapy treatment for hysteria marked the beginning of psychoanalysis (Ehrenreich & English, 1978; Smith-Rosenberg, 1985). Hysteria, feminism, and psychoanalysis therefore

Ussher (2011) argues that such gendered pathologizing and social regulation of women has continued in to the twenty-first century. She positions the diagnosis of major depression as the modern day analogue to hysteria, arguing that women are more likely to be diagnosed because psychiatry continues to “label women as mad, and regulate femininity through psychiatric treatment” (Ussher, 2011, p.63).

The feminist literature about madness does important work in delineating the gendered character of madness and the oppressive effects of psychiatry and psychology on women. However, the main focus is on white, middle to upper class heterosexual women. Some authors make mention of racialized women, lesbians, and working class women, but not substantially. The exception is Chesler (1972), who includes a chapter on lesbians. However, her discussion is riddled with stereotypes about lesbians and gay men and is at times blatantly homophobic. For example, she states, “I must suggest that male homosexuality, *in patriarchal society*, is a basic and extreme expression of phallus worship, misogyny, and the colonization of certain female and/or ‘feminine’ functions” (Chesler, 1972, p.189). The feminist literature is also limited in that any consideration of gender dissidence is limited to the rejection of women’s social roles by otherwise gender normative women. There is no discussion of masculine women, trans women, or any gender dissidence in terms of gender expression, performance, or identity. However, the importance of feminist work in challenging understandings of madness as neutral and objective should not be underestimated.

Thus far I have reviewed historical analyses that point to the social construction of madness, focusing on the racialized, sexualized, and gendered character of knowledge

have a complex relationship and “traverse each other in a complex relation of contestation, implication, and solidarity” (Bernheimer & Kahanem 1985).

production about madness. This historiography has focused on how understandings of madness and mental illness have long been racialized, as well as intertwined with the formation of sexual and gender identity categorizations. This review provides an understanding of elite discourses about madness, but it is also important to review more contemporary critiques that consider the impact on those who have been subject to such conceptions of madness. There are several bodies of thought that are important in this respect: anti-psychiatry studies, gay and lesbian studies, queer studies, and trans studies. While anti-psychiatry studies provides an understanding of some of the resistance to psychiatry in general, gay and lesbian studies, queer studies, and trans studies provides more specific analyses of the pathologizing of non-normative sexualities and gender identities. As will be seen, however, anti-psychiatry studies, trans studies, queer studies, and gay and lesbian studies do not provide a comprehensive consideration of race and racism, drawing attention to the need for an intersectional approach.

Contemporary critiques: Anti-psychiatry studies

Perhaps one of the best-known authors to critique psychiatry and question how medical understandings of mental illness have (re)enforced dominant notions of normativity through the creation of the categories ‘sane’ and ‘insane’ is psychiatrist Szasz. In *The Myth of Mental Illness* he contends that mental illness does not exist. Szasz (1960) makes the controversial claim that the function of the concept of mental illness has been to describe what should rightly be identified as “personal, social, and ethical problems in living” (p. 262). He claims that psychiatry acts as a disciplinary institution that (re)enforces a code of ethics based on predominant worldviews. He compares the concept of mental illness to religion and witchcraft, arguing that they all serve as “social

tranquilizers” (Szasz, 1960, p. 193). As he states, “psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others” (Szasz, 1960, p. 267).

In his later work, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, Szasz (1970) elaborates on this view, comparing the belief in mental illness and institutional psychiatry to the Inquisition and the belief in witchcraft and arguing that they serve the “same social function” in oppressing and controlling the poor and those who transgress social norms (p. xix). Szasz argues that institutional psychiatry regards certain kinds of socially undesirable behaviours as signs of mental illness in order to exert social control and “to validate the Self as good (normal), by invalidating the Other as evil (mentally ill)” (p. xxvii). Szasz emphasizes that his arguments apply only to those who are involuntary psychiatric patients, thus somewhat sidestepping questions concerning those who voluntarily seek psychiatric treatment and self-identify as mentally ill. However, this is an important question to consider. Indeed, Szasz has been critiqued for failing to acknowledge the ‘realness’ of what is known as mental illness for people who experience it and for portraying the mad as passive victims of psychiatry (Ruesch, 1962).

The other author best known for critiquing psychiatry is psychiatrist Laing. Laing rejects the assignation of anti-psychiatry to his work because he sees it as a constructive contribution to psychiatry and does not dispute the basics of psychiatric science (Crossley, 2006, p. 107). Nevertheless, *The Divided Self* has been identified as the “sacred text of anti-psychiatry” (Crossley, 2006, p. 107). In *The Divided Self*, Laing (1960) looks at the case histories of people diagnosed with schizophrenia and uses an

existential phenomenological approach to argue that psychosis is misunderstood by psychiatrists as a biomedical condition rather than a state of being created through social factors. He claims that psychosis is actually a state of detachment from self and others. As he states, “There is a rent in his relation with his world.... There is a disruption of his relation with himself.... He does not experience himself as a complete person” (Laing, 1960, p. 17). His goal is to understand the schizophrenic experience “within the context of his whole being in this world” (Laing, 1960, p. 17) and claims that psychiatrists who treat schizophrenia as a biomedical condition fail their patients because they impose problematic medical approaches and do not understand them.

While Szasz and Laing laid important groundwork for critiquing psychiatry from an ‘expert’ perspective, the literature that arose from the anti-psychiatry movement of the 1960s and 1970s has been key in addressing the impact of positivist understandings of mental health and illness on the lives of those considered mentally ill. This literature points to how those deemed mentally ill face widespread discrimination, as evidenced by a large range of phenomena including the social acceptability of everyday language such as ‘that’s so crazy,’ involuntary incarceration in psychiatric facilities, and the exploitation of psychiatric patient labour (Burstow & Weitz, 1988; Reaume, 2002; Reaume, 2004).

Much of this work focuses on the ways in which psychiatry pathologizes, oppresses, and regulates the lives of those who are deemed mad. Mostly authored by self-identified psychiatric survivors, this work has been crucial in exposing the impact of psychiatry on the lives of those considered ‘mentally ill’. For example, Burstow and Weitz’s (1988) *Shrink Resistant: The Struggle Against Psychiatry in Canada* is an anthology of personal accounts from Canadian psychiatric survivors who challenge the

authority of psychiatry to control their lives and define their identities. Many of the authors demonstrate how psychiatry has been used as a tool of social control, drawing attention to abuses suffered at the hands of psychiatric healthcare professionals under the guise of treatment. They assert their agency by redefining their experiences through the deliberate use of language, such as ‘incarceration’ instead of ‘hospitalization’ (Burstow & Weitz, 1988, p. 23). *Shrink Resistant* repositions psychiatric survivors as the “authorities on Canada's psychiatric system,” an especially important move for a population whose credibility has long been denied (Burstow & Weitz, 1988, p. 32).

Similarly Shimrat’s (1997) *Call Me Crazy: Stories from the Mad Movement* shares personal stories that challenge psychiatry and documents Canadian efforts to create alternatives to the psychiatric system. Shimrat details her own experiences with the psychiatric system that led to her involvement in the mad movement. She also includes the personal stories of other Canadian mad movement activists from the Yukon, British Columbia, Ontario, and Quebec whom she interviewed between 1994 and 1996. Shimrat and her interviewees address the impact of psychiatric abuses such as shock treatment, cold wet packs, lobotomy, and psychiatric drugs. They also outline resistance efforts such as the creation of the anti-psychiatry quarterly *Phoenix Rising* in 1980 and the Ontario Psychiatric Survivors Alliance in 1990.

Another prominent Canadian mad movement activist, Capponi (2003), argues that much of psychiatry focuses on the biological causes of madness to the exclusion of environmental and emotional causes. Capponi argues that social conditions such as poverty and abuse can lead to madness if proper care is not forthcoming. She details the stories of several abuse survivors including her own, demonstrating how such

experiences can have a maddening effect, often made worse by inadequate psychiatric care. She concludes that the lives of many psychiatric survivors could be vastly improved through the fulfillment of basic needs such as access to adequate housing, employment, and friendship.

Canadian mad movement activist and scholar Reaume has made many contributions to this literature. His monograph *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* reclaims the history of people who lived at the Toronto Hospital for the Insane between 1870 and 1940. Reaume (2000) searched patient files for evidence of mad people's voices in order to carefully reconstruct a picture of their lives from their perspectives. In doing so he challenges the authority of medical professionals to define the existence of their patients and restores personhood to the psychiatrized.

Reaume (2002) also explores the shift in terminology regarding people who receive psychiatric treatment. He argues that early shifts in terminology reflected the concerns of mental health care professionals, while more recent changes have been shaped by those who have psychiatric histories (Reaume, 2002, p. 405). Reaume also outlines some of the disagreements amongst those who receive psychiatric treatment as to what terminology is appropriate, while emphasizing the underlying common desire to have those with psychiatric histories be seen as “a person rather than a label” (p. 424). Reaume provides a history of terms that are often thoughtlessly used in common parlance today such as ‘lunatic,’ ‘imbecile,’ and ‘idiot’ and examines the politics of labelling and self-definition.

At the heart of all of these works is the desire to improve conditions for mad people. Anti-psychiatry studies have made an important contribution to challenging the power of psychiatry and empowering mad people. This literature points to how the voices of mad people have long been silenced by psychiatric ‘experts’ as well as by commonly held prejudicial beliefs that dictate that mad people are incapable of speaking for themselves. Anti-psychiatry studies seek to rectify this and constitute the mad as agents in their own right. However, there are few texts that address how current understandings of madness and mental illness affect marginalized groups, such as racialized people and/or LGBTQ people. Indeed, there is little written addressing the experiences of mad people who also identify as LGBTQ, and the work that does exist is often autobiographical (see for example Scholinski, 1997). Even autobiographical collections such as the groundbreaking *Shrink Resistant: The Struggle Against Psychiatry in Canada* and *Call Me Crazy: Stories from the Mad Movement* include limited discussion of the experiences of marginalized groups such as LGBTQ people and/or racialized people. As the editors of *Shrink Resistant* acknowledge, the “psychiatrization of ‘minority groups’” is barely covered in the anthology, and they “apologize to the elderly, the disabled, the gay community and, most especially, our sisters and brothers of colour for these omissions” (Burstow & Weitz, 1988, p. 26). *Shrink Resistant* was published in 1988, but there are still major gaps in the literature regarding racialized and LGBTQ people in particular. Furthermore, these groups are obviously not mutually exclusive, but it is a challenge to find work that is not singularly focused on either race or sexuality. In this way, anti-psychiatry studies could benefit from analyses present in work regarding the psychiatrization of LGBTQ people in gay and lesbian studies, queer studies, and trans

studies. Many scholars in gay and lesbian studies, queer studies, and trans studies have examined the issues pertaining to the inclusion of homosexuality in earlier versions of the DSM and the current inclusion of gender dysphoria (previously gender identity disorder).

The next section reviews some of this work.

Contemporary critiques: Sexuality and gender identity in the Diagnostic and Statistical Manual of Mental Disorders

Arguably the most important text for understanding current conceptions of mental illness, the Diagnostic and Statistical Manual of Mental Disorders (DSM) outlines psychiatric disorders and the diagnostic criteria used by mental health professionals. DSM-I (1952) and DSM-II (1968) were relatively short and “served largely documentary and administrative purposes” (Lewis, 2006, p. 100). The DSM underwent major revisions for the publication of the third edition in 1980. These revisions occurred following many challenges to psychiatry, including the work of Foucault (1961) and Szasz (1960, 1970) (amongst others), the anti-psychiatry movement, and the controversy regarding the inclusion of homosexuality in the DSM-I and DSM-II. These challenges “threatened the very foundation of psychiatry’s medical and scientific legitimacy” (Lewis, 2006, p. 99). Many scholars claim that the revisions to DSM-III re-entrenched the disease model of mental illness in an effort to rehabilitate the legitimacy of psychiatry by more firmly establishing it as a science (Kurt & Kutchins, 1992; Lewis, 2006; Maracek & Gavey, 2013; Rapley, 2012).

This rehabilitation was largely successful; however, the DSM continues to be critiqued on scientific grounds, with questions raised, for example, on issues of diagnostic reliability and validity (Kurt & Kutchins, 1992; Kurt & Kutchins, 1997; Johnstone, 2006; Thomas, 2013). These critiques often also go beyond challenging the

DSM's empirical evidence base and point to the ways in which diagnostic criterion are enculturated, as opposed to objective and neutral. The historical debates regarding the inclusion of homosexuality and related diagnoses and ongoing concerns with the inclusion of GID and gender dysphoria illustrate and support such critiques, showing how social values are embedded in psychiatric diagnoses.

Homosexuality was included as a disorder in the first (1952) and second (1968) editions of the DSM. The APA board of trustees voted to remove it in 1973, due in large part to pressure from gay and lesbian activists (Bayer, 1981). This decision was challenged, leading the APA to hold a referendum on the matter. The majority voted to uphold the decision, but at this time the APA also created the diagnosis of sexual orientation disturbance to pathologize those unhappy with their homosexuality (Stein, 2012, p. 110). This was replaced with ego-dystonic homosexuality (EDH) in the DSM – III (1980). EDH quickly met with criticism from gay and lesbian activists and did not appear in the revised DSM – III – TR (1987). The DSM – III also included the diagnosis gender identity disorder for those displaying 'gender variant' behavior; the diagnosis was required for those seeking sex reassignment surgeries. GID was changed to gender dysphoria (GD) in DSM-5 (2013) and continues to be the subject of intense debate (see for example Daley & Mulé, 2010). While homosexuality is no longer officially diagnosed as a mental illness, GID has been used to pathologize both queer and trans people, as will be discussed below. Gay and lesbian studies, queer studies and trans studies have done much to explicate the meaning and impact of these diagnoses.

For example, Bayer (1981) charts the history of the declassification of homosexuality as a mental disease in the DSM, arguing that this struggle provides insight

into the relationship between psychiatry and society. Bayer argues that the process through which this change took place exposed the normally obscured enculturated nature of dominant concepts of health and illness. As he states,

Because concepts of disease and health take form within cultural contexts in ways that often remain hidden from view, the process of change through which certain deviations become labelled as normal or abnormal remains difficult to discern, becoming clear only when historical or social conditions permit the piercing of the veil of 'the natural.' (Bayer, 1981, p. 13)

Bayer contends that psychiatric designations of 'normal' and 'abnormal' are intricately tied to predominant social values and the decision to declassify homosexuality took place because the social conditions of the 1960s created a favourable environment for gay activists to push for such change. Challenges to prevailing social values from various social movements, including the women's movement, the civil rights movement, and the anti-psychiatry movement, overlapped with the demands of gay liberation activists for acceptance as mentally healthy members of society. Bayer further argues that while psychiatry reflects dominant views, it also changes them. The APA decision to remove homosexuality from the DSM is one such example, as it helped legitimize homosexuality to a certain extent (Bayer, 1981, p. 14).

Minton (2002) takes a somewhat different approach in that he focuses on how gays and lesbians have used science in emancipatory ways. Rather than focusing on the ways that science has been used to oppress gays and lesbians, he demonstrates how gays and lesbians contributed to scientific knowledge production about sexuality in order to fight for their rights, though their work often went unrecognized. In an effort to rectify

this lack of acknowledgment, he describes the unpublished work of lesbian and gay activist-researchers of the early and mid-20th century. Minton's work highlights gay and lesbian agency as well as the positive uses of science.

Minton (2002) ends with a chapter on the depathologizing of homosexuality, focusing on activist-researcher contributions. Under the subheading “Sanity and Empowerment,” he describes what he sees as the impact of the APA's decision to delete homosexuality from the DSM:

Thrusting off the straitjacket of sickness empowered gay men and lesbians in two ways. First, it accorded them a sense of personal pride and group solidarity, resources necessary to resist the power of heterosexist ideology... Second, removing the official stamp of illness enabled gay people and their supporters to establish a legitimate foundation for communication (such as gay and lesbian studies) (Minton, 2002, p. 262).

This is a fairly typical characterization of the benefits of declassifying homosexuality as a mental illness. However, it is problematic in that it suggests that pride, solidarity, and ‘legitimate’ communication are not possible when one is considered mad, ignoring the efforts and successes of the anti-psychiatry movement, mad pride, and mad scholarship. It also rather uncritically reinforces the notion that legitimacy is tied to being seen as sane without acknowledging that this is still a problem for those deemed mad, whether queer or not. Minton also seems somewhat glib in suggesting that the official removal of homosexuality and EDH from the DSM would put an end to the pathologizing of gays and lesbians.

As Sedgwick (1993) points out, the first DSM to drop the diagnosis of homosexuality (DSM III) was also the first to list gender identity disorder. She contends that this new diagnosis continued the work of pathologizing effeminate boys (and to a lesser extent masculine girls) that was previously accomplished through the diagnosis of homosexuality. Sedgwick claims that the gay movement has been reluctant to protest this new diagnosis and its impact on effeminate boys, as it is eager to distance itself from the association of effeminacy with homosexuality and the attending conflation of gender and sexuality. She contends that psychiatry is one of the many institutions that work towards the eradication of gay people and that GID is just one more tool in the arsenal. Written in 1993, this article does not consider the impact of GID on trans people or the ways in which the trans movement has engaged the diagnosis.

More recently Butler (2004) has outlined current debates within gay, lesbian, bisexual, queer, trans, and intersex (GLBQTI) communities about whether or not gender identity disorder (GID) should be removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Some argue that the listing of GID in the DSM allows trans people access to medical services they might not otherwise be able to obtain, thus enabling trans autonomy. Butler acknowledges the need for access to body modification procedures, but argues that the access to services enabled by GID comes at the cost of submission to the pathologizing discourse of psychology. As she states, “One must be subjected to a regulatory apparatus...in order to get to the point where something like an exercise in freedom becomes possible” (Butler, 2004, pp. 90-91). She argues that GID is particularly dangerous for youth, who may not have the resources and support to resist the pathologizing force of the diagnosis. Butler contends that GID (re)produces and

(re)enforces gender norms, acting as a form of social violence as well as a form of social recognition.

Like Butler (2004), Spade (2006) argues that GID is a form of social violence. He uses his experiences of seeking sex reassignment surgery (SRS) to examine the ways in which GID enforces normative ways of being gendered. He finds that those who present a gendered sense of self that does not fit the diagnostic criteria for GID are seen as not ‘truly’ transsexual and unsuitable candidates for SRS procedures. Many trans people feel compelled to perform their gender according to “their prior knowledge of the diagnostic criteria” to be seen as ‘authentically’ trans by medical practitioners and gain access to hormones and surgeries (Spade, 2006, p. 326). Spade argues that the imperative to present a narrative that heavily ascribes to normative conceptions of masculinity and femininity serves to eradicate “norm-resistant possibilities” (Spade, 2006, p. 325). He concludes that a “disability– or disease-based understanding” of gender variance denigrates trans people and is “too high a price to pay for a small hope of conditional tolerance” (Spade, 2006, p. 329).

Lev (2005) examines how the diagnosis of GID is problematic in that it pathologizes both trans and homosexual people. Lev argues that trans people are seen as mentally ill by virtue of being trans, as a “mental illness model leaves no room for the recognition of mentally healthy and functional transgender and transsexual people who may desire sexual reassignment treatments” (p. 48). Further, GID is also sometimes used to diagnose gender variant homosexuals who are not transgender by clinicians who continue to see homosexuality as a mental illness (Lev, 2005, p. 50). Lev contends that GID is often used to target gender variant children (who may grow up to be either

homosexual or transsexual) under the guise of protecting them from peer bullying. She also points to the sexist character of the diagnostic criteria, which rely on “stereotypical definitions of ‘normal’ male and female behaviour” (Lev, 2005, p. 51). Lev concludes that GID is an example of psychology using moral criteria to pathologize behaviour that does not conform to social norms. She suggests that GID should be reformed in such a way that would depathologize gender variant behaviour, yet still allow for access to medical treatment for transgender and transsexual people. As she states, “approval for medical treatment should not depend on being mentally ill, but on being mentally sound enough to make empowered and healthy decisions regarding one's body and life” (Lev, 2005, p. 59).

More recently, Daley and Mulé (2010) wrote a position paper in response to the APA's solicitation of input into revisions proposed to various diagnoses for the publication of DSM-5 in 2013. Regarding gender identity disorders, they recommend the removal of the proposed diagnosis of gender incongruence in children (formerly gender identity disorder in DSM III and IV) on the basis that this results in the “surveillance and pathologizing” of children who are non-normatively gendered and sexualized and the reinforcement of gender and sexual norms (Daley & Mulé, 2010, p. 3). Regarding the inclusion of gender incongruence in adolescents and adults (formerly gender identity disorder in DSM III and IV), they state that they are politically aligned with the position of removing it altogether, but recognize that a diagnosis is still necessary for trans people to access health insurance coverage. Echoing Lev (2005), they call this “gate keeping” that represents “systemic abuses of power” and urge governments to make changes to these regulations to allow trans people to access insurance coverage without a diagnosis

(Daley & Mulé, 2010, p. 4). They note that a change to the regulations is “a keystone” in the depathologizing of trans people (Daley & Mulé, 2010, p. 4). Further, they recommend listing gender identity disorders and sexual paraphilias under Axis IV (psychosocial and environmental factors contributing to the disorder) rather than Axis I (clinical disorders), where they are currently listed, in order to “support recognition of the social, cultural and political forces related to the social construction of sexual and gender identities as mental illnesses and marked distress as a result of the stigmatization of, and discrimination against, diverse sexual and gender identities” (Daley & Mulé, p. 11). Daley and Mulé (2010) also support a number of the proposed changes, including the name change from gender identity disorder to gender incongruence, as this would “avoid establishing a ‘natural’ association between discomfort/distress and one’s experience of gender incongruence as might be implied...by the use of the term gender dysphoria” (p. 5).⁴

This focus on the problematic pathologizing of LGBTQ people is very important. However there is a lack of research that addresses the experiences of LGBTQ people who do in fact self-identify as mad and/or those who have had been given a mental illness diagnosis aside from GID. In some respects the common emphasis in the literature on the importance of distancing LGBTQ people from mental illness may reflect and promote ableist beliefs about madness. For example, Spade’s (2006) critique of a disability-based understanding of transsexuality fails to unpack the ableism inherent in medical discourses about gender variance and the role of ableism in the desire to reject a disability-based model. Likewise, Lev’s (2005) analysis raises the question of how we decide who is “mentally sound enough” to exercise decision-making power. In doing so, she leaves

⁴ Gender identity disorder was changed to gender dysphoria in DSM-5. Gender dysphoria in children was not removed. Gender dysphoria is no longer listed under ‘sexual disorders’ (as was GID), and has its own chapter. DSM-5 discards the multi-axial diagnostic scheme altogether.

intact the ableist assumption that those who are ‘mentally ill’ are incapable of making “healthy decisions” about their own lives.

The distancing of marginalized groups from the notion of disability as a tactic of fighting for equality has a long history. Baynton (2001) points to the history of “women’s suffrage, African American freedom, and immigration restriction” as examples of the ways in which oppressed groups have been labelled disabled as a way of justifying oppression and inequality (para. 1). He argues that the efforts to combat marginalization in these three contexts focused on resisting the label of disability, rather than arguing that disability is not grounds for inequality. He contends that this suggest that there is “tacit acknowledgement across the political spectrum that when disability is present, inequality is indeed justified” (Baynton, 2001, para. 8). Gay and lesbian studies, queer studies, and trans studies must be careful not to perpetuate ableism and sanism in the service of arguing against the pathologization of LGBTQ people. In this way gay and lesbian studies, queer studies, and trans studies could benefit from analyses present in anti-psychiatry activism that advance critiques of ableism and sanism and reclaim madness as a source of pride and solidarity.

These types of concerns are evident on both a theoretical and an everyday level. At a recent Canadian Institute for Health Research (CIHR) funded Café Scientifique regarding LGBT people and mental health, frustration erupted during the question and answer period.⁵ Some members of the audience were angry about the lack of acknowledgment of LGBTQ people in Toronto's mad community, as well as the lack of acknowledgment of mad people in queer and trans communities. Others expressed anger

⁵ Rewriting a History of Pathologization: LGBT People and Mental Health Research in Canada, hosted by the Sherbourne Health Centre in collaboration with CIHR, June 8, 2011, at the Gladstone Hotel, Toronto ON.

about the white-centricity of both communities. Some audience members told of ableist experiences in queer communities, often based on efforts to distance queerness from madness. Some felt that the Café Scientifique did not go far enough in addressing these concerns and was simply capitalizing on mad LGBTQ people as another academic trend. The presence of these concerns in both the academic literature and the everyday lives of mad people indicates the need for respectful social research that addresses these issues and highlights the potential concerns in doing so. In the final section of this chapter, I explain my methodological decisions in carrying out my research.

Qualitative interviewing

For this project I conducted 37 qualitative interviews with LGBTQ people about their experiences of mental distress. Nineteen participants were recruited in Winnipeg, Manitoba, and 18 in Toronto, Ontario. I chose to interview in Winnipeg, Manitoba, and Toronto, Ontario, in order to allow for the possibility of making comparative assessments and exploring the differences between living in a metropolis with a strong psychiatric survivor community and a smaller city with fewer community resources.

Toronto, the biggest city in Canada with a population of about 2.79 million and 5.5 million in the Greater Toronto Area, is much more heavily populated than Winnipeg, the capital of Manitoba, which has a population of approximately 700,000. Yet the two are both ‘big cities’ in that Winnipeg is the largest city in Manitoba and larger than the second biggest city, Brandon, by approximately 68,000 people. According to the 2011 census, Toronto has the largest number of residents who are immigrants, at 49% (Statistics Canada, 2013a). In comparison, 28% of Winnipeg residents and 21% of Canada’s total population are immigrants (Statistics Canada, 2013b). Forty-nine percent

of Toronto residents identified as “visible minorities” as opposed to 21% in Winnipeg and 19% nationally (Statistics Canada, 2013a; Statistics Canada, 2013b). The top three visible minority groups in Toronto are South Asian (12% of Toronto’s total 2011 population), Chinese (11%), and Black (9%) (Statistics Canada, 2013a). In Winnipeg the largest groups are Filipino (9% of total 2011 population), South Asian (4%) and Black (3%) (Statistics Canada, 2013b). The most commonly reported “ethnic origins” amongst Toronto residents are English (13% of Toronto’s population), Chinese (12%) and Canadian (11%) (Statistics Canada, 2013a). In Winnipeg the biggest groups are English (21% of Winnipeg’s population), Scottish (17%) and Canadian (17%) (Statistics Canada, 2013b). Toronto’s Aboriginal groups make up 0.8 percent of the total Toronto population, compared to 11% of Winnipeg’s and 4.3% nationally (Statistics Canada, 2013a; Statistics Canada, 2013b).

As these numbers show, Toronto is unusual in that it is home to significantly more immigrants and ‘visible minorities’ than any other Canadian city. In this respect, Winnipeg is a more typical Canadian city, and including it as a research site allows me to extend my analysis beyond Toronto. Further, as the province with the largest population and 40 universities, Ontario is often the site of Canadian research studies. Southwestern Ontario and Toronto in particular, with its large and diverse population, is a common choice for researchers.⁶ Adding a second, less researched site broadens the perspective and shows what commonalities exist, despite any provincial and local differences.

Indeed, I found that there were far more similarities than differences in the participants’ narratives, and these are emphasized throughout the dissertation.

⁶ Of these 40 Ontario universities, 23 are publicly funded and 17 are privately funded religious institutions. In comparison, Manitoba has 7 universities, three of which are publicly funded and four of which are privately funded religious institutions.

I began interviewing in August 2010 and completed the interviews in February 2012. Qualitative interviewing offered a unique opportunity to engage in meaningful dialogue and collect rich data. The participants were generous with their time and stories and shared extensively with me. This kind of data can not be acquired through most other methods. A quantitative study on this topic would provide an interesting statistical overview, but would not yield in-depth experiential accounts. The voices of mad LGBTQ people are rarely represented in textual sources, so my interviews are an invaluable source of first-person accounts of everyday life experience.

Indeed, one of the benefits of using qualitative interviews as the research method for this project is to ensure the presence of the participants' voices in this dissertation. This is particularly important when studying marginalized groups, since their voices have often been ignored and silenced. As Gamson (2000) contends, qualitative research methods "make more room for voices and experiences that have been suppressed" (p. 347). Indeed, queer, feminist, and antiracist researchers often make use of qualitative methods for this reason (Browne & Nash, 2010). Qualitative interviews allow more space for exploring and presenting participants' voices than other methods such as surveys or questionnaires. As Fine and Kidder (1997) argue, the nature of qualitative data "is not simply that they are 'not numbers,' but that they are analyzed with an ear for what informants are saying rather than an eye on predetermined categories and hypotheses" (p. 47).

More specifically, ensuring the presence of participants' voices is crucial for projects that include participants who have been positioned as 'mentally ill,' as the knowledge and

experiences of mad people have long been discounted. As Lapsley, Waimarie, & Black (2002) state,

Traditionally, users of mental health services have been stigmatised, regarded as unreliable sources, and denied a voice in the literature of mental health. Linking mental illness (madness or lunacy) with unreason, excess, incapacity and unreliability are historically entrenched attitudes in Western societies. These attitudes sit alongside the growth of power and expertise in the medical and helping professions which have led to the denial of a voice for clients/consumers (p. 4).

I believe it is very important to privilege the participants' voices as experts on their own lives and experiences. For this reason I make use of long block quotations throughout this dissertation and minimize my own paraphrasing and rewording of their experiences. I offer a critical analysis of the interview material and frame interviewees' responses through my choices about which questions to ask and which quotations to use. However, I tend to present the interview material as it stands, rather than extrapolating from what participants have said. This is my attempt to minimize the potential of perpetuating "oppression and stigmatization of consumers through the reinterpretation of lived experience" something that Phillips (2006) contends is a widespread phenomenon (p. 173).

Qualitative interviewing also allows for a certain amount of flexibility in the interview process. I created an interview guide of open-ended questions about identity, health, work, and community that functioned as a base from which to start. Additional questions arose throughout the individual interviews. Listening carefully to interviewees

and adding new questions accordingly can make the interviewer, the interview, and the study more “interviewee oriented” (Bart & O’Brien as cited in Reinhartz, 1992, p. 21). The open-ended interview format allowed me to follow up on various comments made by participants with new questions, although I always returned to the interview guide in order to maintain some consistency among interviews.

Another advantage of qualitative interviews is that they allow space for a more nuanced discussion of self-identity. As Warner (2004) states, “Any attempt to quantify homosexuals, heterosexuals, etc., assumes a commonality between the individual’s desires and lives that is suspect. Qualitative approaches have a better chance of accounting for queer experiences in the same terms as the actual people living these experiences” (p. 335). Warner is referring specifically to sexuality categories, but I think his point is also applicable to gender, race, class, and dis/ability. To get a sense of how participants identify, I asked the open-ended question, ‘How do you describe yourself in terms of sexuality, gender, race, class, and disability?’ Many of the participants provided complex discussions of many aspects of their identities, which points to the difficulties of quantifying or simplifying any aspect of identity, not just sexual identity. For example, one participant described his race, class, sexuality, gender, and disability as “liminal” and “not easily defined as one or the other.” He discussed being perceived as white, racialized, able-bodied, disabled, and a long list of queer, trans, and cisgender identities, depending on the circumstances. As he told me, “everything about me is so complicated and hard to point out.” This participant’s response points to the limitations of identity categories to capture the experiences of those who don’t consistently pass as “one or the

other.” I found that qualitative interviewing allowed for more detailed discussions of these complexities.

However, it is not my intention to argue that there should be an imperative for queer, feminist, and antiracist scholars to make use of qualitative methods only. As Browne and Nash (2010) argue, there is no single “queer method” and it is unwise to discount quantitative methods. As they state, “There is a danger in... asserting that queer epistemologies, methodologically, require the use of qualitative methods only, or must always contest traditional and conventional techniques” (Browne & Nash, 2010, p. 12). While I believe that qualitative interviewing is the best choice of method for my project, I would argue that a thorough consideration of methodological choices and ethics in research practice is equally if not more important than the method.

Terminology and methodology

The depth of discussion of identity elicited in the interviews was very important, but also created challenges for my writing in terms of choosing language for referring to the study participants as a group. I asked participants to self-identify using whatever words they felt most comfortable with instead of choosing from a list of my creation. I made this choice because I believe that self-identification is particularly important for groups who have long been defined by others. When it came time to write a demographic breakdown of the study participants, I struggled with creating a coherent description from the long and varied list of terms used by the participants. I have made sense of this as follows (see Appendix A for a chart version of the following).

The research participants were between the ages of 20 and 49, with 51% (19) in their 20s, 35% (13) in their 30s, and 14% (5) in their 40s. In terms of gender, 49% (18) of

participants identified as female and 38% (14) identified as male. Of the female participants, 17% (5) also identified as trans and/or genderqueer, as did 50% (7) of the male participants. The remaining 14% (5) of participants did not specify either male or female, identifying simply as trans and/or genderqueer. Many participants used more than one term to describe their sexuality; 62% (23) identified as queer, 22% (8) as gay, 14% (5) as lesbian, 8% (3) as bisexual, 5% (2) as pansexual/omnisexual, and 3% (1) as heterosexual. The participants also used many terms to describe their race and ethnicity, but broadly speaking 59% (22) of participants identified as white and 41% (15) identified as racialized. In addition to identifying as white, 5% (2) identified as French Canadian, 5% (2) as Eastern European, 3% (1) as Western European, 3% (1) as Scottish, and 3% (1) as Jewish. Of the participants who identified as racialized, 11% (4) identified as black, 11% as Métis (4), 11% (4) as mixed race/biracial, 5% (2) as Aboriginal, 3% (1) as brown, 3% (1) as Korean, 3% (1) as East Asian, 3% (1) as South Asian, 3% (1) as Middle Eastern, 3% (1) as Indonesian, and 3% (1) as Muslim. Just over half of the participants (51%) (19) identified as low income and the remaining 49% (18) identified as middle class. In terms of disability, 51% (19) of participants identified as having one or more physical and/or mental disabilities. It is important to note that the numbers for sexuality and race do not add up to 100 because many participants identified with more than one term⁷.

In the initial stages of researching and writing I used the phrase ‘queer and/or trans,’ and ‘lesbian, gay, bisexual, queer, and/or trans’ (LGBTQ) to refer to the participants as a group. I envisioned ‘queer’ and ‘trans’ as umbrella terms that would

⁷ This sample is limited in that it does not include youth and those over 50, those who are incarcerated in prisons or psychiatric institutions, those who do not have documented status in Canada, and those who identify as Filipino or Latin American.

encompass a longer list of identity categories such as lesbian, gay, bisexual, and transgender, transsexual, and genderqueer. However, after careful consideration of the demographics I have decided to use ‘LGBTQ’ to refer to the participants. While many (62%) used the term ‘queer’ to describe themselves, there are enough who did not to warrant the use of ‘LGBTQ.’ It is important to note that ‘LGBTQ’ still subsumes some identities. Notably, the ‘T’ that stands for ‘trans’ still serves as an umbrella term for the participants who identified as trans, transgender, transsexual, and genderqueer.⁸ However, ‘LBGTQ’ is more inclusive of the lesbian, gay, and bisexual participants who did not use ‘queer’ to describe themselves.

While I have chosen to use ‘LGBTQ’ to refer to the participants, I do make use of ‘queer’ throughout this dissertation. At times, I employ ‘queer’ as an identity category. Early uses of ‘queer’ in the late 1980s and 1990s by academics and activists such as Queer Nation were often anti-identitarian. ‘Queer’ was seen as impossible to fully define, “a zone of possibilities” (Edelman, 1994, p.114). ‘Queer’ shifted the focus from identity to acts, desires, bodies, and performances, drawing attention to “mismatches between sex, gender and desire” (Jagose, 1996, p. 3). While queer still references such mismatches, it has also been taken up as an identity category. As Gamson (2000) contends, the term ‘queer’ can be used to “mark an identity that, defined as it is by a deviation from sex and gender norms either by the self inside or by specific behaviours, is always in flux” (p. 349).

The participants who used ‘queer’ to describe themselves used it as an anti-homonormative identity category that is expansive and fluid enough to encompass attractions, bodies, desires, and sexual practices that challenge normative understandings

⁸ None of the participants identified as two-spirit.

of sex, gender, and sexuality. For example, when asked what ‘queer’ means to him, one participant said, “it is a way of positioning myself outside of gay and lesbian politics.” He went on to describe how ‘queer’ also solved some of his difficulties in explaining his sexuality to others. As a trans person attracted to “a variety of different bodies and sexualities” including those who don’t identify as male or female, this participant saw ‘queer’ as “much more inclusive” term and more capable of conveying “the multi-dimensionality of desire.” For this participant, as for many, the term ‘queer’ serves both political and identitarian functions and encompasses a complex set of attractions, desires, bodies, and sexual practices. When I make use of the term ‘queer’ throughout this dissertation, it is often in this sense: to reference politics, identity, and gender and sexual dissidence.

When it came time to compose the call for participants, I also struggled with what terminology to use in terms of mental health in order to reach the people I was interested in interviewing. In my dissertation proposal, as above, I stated that I would be conducting interviews with those who self-identify as mad or mentally ill or who had been deemed as such (or, alternatively, psychiatric survivor, psychiatric service user or consumer) and who also identify as queer, gay, lesbian, bisexual, and/or trans. I chose this terminology to describe the participants I sought in order to be as inclusive as possible. I included the language ‘deemed as such’ as well as ‘self-identify’ in order to indicate that I was interested in speaking with those who have a medical diagnosis concerning their mental health as well as those who do not, in order to avoid perpetuating the notion that medical authorities should be the ones to distinguish the ‘sane’ from the ‘insane.’ I was not interested in framing my population sample in terms of how the participants have been

diagnosed, as I believe this ascribes too much weight to medical categorization, and I wanted to capture a range of attitudes towards diagnosis and self-identification. For example, I anticipated that some participants may reject medical labels altogether, some may use them in certain contexts and not others, and others may fully embrace them. Indeed, the reasons for these kinds of choices and the process of self-identification will be among the topics I explore in this dissertation.

However, I found that my initial call for participants was unsuccessful in conveying who I was looking for. I asked several people who had indicated to me that they would be interested in participating when I described my project verbally for feedback on the written call for participants. I was told that the terms ‘mad’ and ‘mentally ill’ were too ‘strong’ and that both conveyed pathology and sickness in a way that was not appealing. With this helpful feedback in mind, I revised my call for participants to state that I was looking for those who felt that mental health had personally and directly affected them. Though I would argue that we all have a personal and direct relationship to mental health, this phraseology in combination with a more specific list of identities (psychiatric survivor, mad, psychiatric service user, consumer, and mentally ill) was successful in reaching a more inclusive group of people. Interviewees used a large variety of terms to refer to their identities in terms of mental health, including various psychiatric diagnoses, crazy, mad, psychiatric service user, psychiatric survivor, consumer, and mentally ill. This assortment of terms reflects the participants’ range of approaches to conceptualizing madness or mental health. Some participants rejected the medical model of ‘mental illness’ and eschewed medical labels altogether, choosing more politicized terms to describe themselves. Some used medical model language strategically, for

example to make themselves intelligible in certain contexts such as in healthcare facilities and the workplace. Others embraced the medical model and employed the term mentally ill unequivocally. Though the participants used a wide variety of terms, I have chosen to use the terms ‘madness,’ ‘mental distress,’ and ‘mental health’ in my written work for the reasons described in my introduction.

Recruitment and conducting interviews

Participants were recruited through posting notices in various health-related and/or queer-centered locations and through online means. In Winnipeg I posted hard copy notices at the Rainbow Resource Centre, Nine Circles Community Health Centre, Manitoba Harm Reduction Network, Sage House, Four Rivers Medical Clinic, Mount Carmel Clinic, Klinik Community Health Centre, and the Canadian Mental Health Association. I sent online notices through the Rainbow Resource News, the listserv for the University of Winnipeg’s Lesbian, Gay, Bisexual, Trans Centre, and the listserv for the Sexuality Education Resource Center Manitoba (SERC).

In Toronto I posted hard copy notices at the Centre for Women and Trans People at York University and the office space for the Trans, Bisexual, Lesbian, Gay Allies at York University (TBLGAY). I circulated a call for participants on the Mad Student Society Listserv, the Consumer/Survivor Information Centre Resource Bulletin of Toronto, York University’s listerv for the Centre for Women and Trans People (CWTP), the Trans, Bisexual, Lesbian, Gay Allies at York University (TBLGAY), the Lesbians, Gays, Bisexuals, and Transpeople of the University of Toronto (LGBTOUT), and on the Rainbow Health Ontario website. I also recruited through personal networks of friends and acquaintances in both cities through word of mouth, e-mail, and Facebook. I believe

that 37 interviews provided an adequate amount of data that allowed me to hear a range of voices and identify major themes.

Setting up the interviews took place mainly over e-mail, with only a few interactions taking place over the telephone. Participants were given the option to choose any public space where they felt comfortable to do the interview. Most Winnipeg participants chose my suggestion of the University of Winnipeg and most Toronto participants chose my suggestion of the Ontario Institute for Studies in Education (OISE). While I hesitated to suggest potentially intimidating academic institutions, I chose to suggest the University of Winnipeg and OISE for their centrality and the availability of more private spaces for interviewing.

Participants were informed that the digitally recorded interview would be approximately 45 minutes to 2 hours in length, that they were free to withdraw from the study at any time without penalty, and that they were not required to answer any questions considered to be inappropriate, invasive or offensive. Participants were informed that there was no compensation for participating in the study. All participants were given the option to receive a transcript of the interview after it was transcribed in order to review it and make any changes before I made use of it. Twenty-six participants asked for a copy of the transcript and 4 made minor revisions by clarifying and adding additional comments. Transcribed interviews were coded for common themes using NVivo coding software.

Ethical research practice

Confidentiality and anonymity are important aspects of ethical research practice. On the interview consent form I gave participants the option to use their legal name or to

choose a pseudonym. I phrased this as follows, “You have the option to use a pseudonym or to use your real name. Please indicate the name you would like used.” I provided a blank space following the words, “pseudonym or name.” I also explained this option verbally as participants were filling out the consent form and made sure they were aware of what they were agreeing to. In the space provided, 4 participants gave their legal first and last names, 14 gave a pseudonym or asked me to choose one, and 19 gave their legal first name only. For the sake of consistency, I make use of first names only, whether legal or pseudonymous.

Another salient ethical issue specific to my population sample is the prevalent well-founded distrust of academic research and researchers based on the exploitation of marginalized groups by academics. Many scholars have pointed out that disabled people and specifically those with psychiatric disabilities have been subjected to unethical research practices and treated in ableist ways by researchers (see for example Oliver, 1992; Phillips, 2006; Shakespeare, 1996b; Wilton, 2004). Research has often been used against the best interests of people with disabilities, and as Wilton (2004) argues, those working for psychiatric survivors’ rights “have critically interrogated the motivations of researchers, and with good reason given the way in which scholarship has been used to legitimate the social and spatial exclusion of people with physical and psychiatric disabilities” (p. 117).

The methodological literature concerning people with psychiatric disabilities tends to compare this exploitation and the resulting suspicion of researchers on the part of people with disabilities to what has happened to ‘other’ oppressed groups. Wilton (2004) exemplifies this common comparison when he states, “Like other oppressed populations,

disabled people have come to regard academics, especially non-disabled academics, and academic research with suspicion” (p. 117). This comparison is problematic because it assumes that people with psychiatric disabilities are oppressed only on the basis of their disability, suggesting that they are therefore white, heterosexual, cisgender, and class privileged. As Grillo and Wildman (1991) have pointed out, similar analogies made about gender discrimination and race discrimination naturalize whiteness and erase the experience of those who experience various forms of oppression as indivisible and mutually constitutive. As they state,

To analogize gender to race, one must assume that each is a distinct category; the impact of which can be neatly separated, one from the other. The essentialist critique shows that this division is not possible. Whenever it is attempted, the experience of women of color, who are at the intersection of these categories and cannot divide themselves to compare their own experiences, is rendered invisible. (Grillo & Wildman, 1991, p. 404)

Though Grillo and Wildman are referring here to comparisons made specifically about sexism and racism, their argument applies to the assumptions made in the methodological literature about people with psychiatric disabilities. This does not mean that analogies should never be made; presumably it is possible to analogize without erasing those who experience discrimination as mutually constitutive. However, it is not possible to isolate one dimension of experience and identity as the only or most salient factor in creating mistrust of researchers.

Many of the people I interviewed occupied multiple subject positions that may have led to well-founded suspicion of academic research and researchers. Trans people,

queer people, racialized people, low income people, and people with disabilities have all been the object of knowledge production that has either erased their existence or otherwise exploited them. My population sample included people from all of these identity categories, many of whom, of course, identified with more than one of the above.

It is possible that more transparency about my own subject position could have helped ease fears about exploitative academic researchers. Many feminist researchers argue that such transparency is part of establishing rapport with participants and balancing power relations in the research process (see for example England, 1994; McDowell, 1992). I respect researchers who take this approach, but decided not to do so myself. I did not explicitly disclose anything about my subject position to participants unless they asked. The participants who were recruited through personal networks or who recognized me from queer and trans communities in Winnipeg and Toronto no doubt knew more about my subject position than those who were strangers. However, my self-presentation read as queer and genderqueer at the time of the interviews and it is my sense that all of the participants understood me as such.

I also did not discuss my own relationship to mental health unless asked. A few participants asked probing questions about my interest in the topic. In these cases I provided both academic and personal reasons for my research interests. I also made my ideological positions as clear as possible with all participants, emphasizing that I respect how people define their own identities and experiences. It is my hope that my demeanor also helped reassure participants. I related to them as a peer, rather than as a distant professional. This was not forced; it reflects how I felt about the interviewees. ‘Coming out’ to participants can be powerful, but it is not always necessary in order to achieve

rapport and combat well-founded fears of exploitation. Nor does researcher transparency about subject position guarantee respectful research practice. It is my sense that I managed to make participants feel comfortable and I received positive feedback confirming this from several interviewees.

It is also important to note that what constitutes ethical research practice is subjective. As Philips (2006) states, “The interpretation of what constitutes morally right and ethical research is a matter of agreement among members of a particular group at a given time; unsurprisingly, different groups will interpret this in different ways” (p. 175). The truth of this was brought home to me during the research process. One participant told me that upon hearing about her involvement in my study, a friend expressed dismay and concern that a researcher who was not professionally trained as a clinician would undertake research regarding mental health. I believe that this kind of concern reflects an inability to conceptualize research about mental health outside of a medicalized context and positions mad people as fragile, volatile, and in need of protection from medical professionals.

This type of ethical concern; when it comes to interviewing people about mental health, is widespread. As Holland (2007) argues, ethics review boards often take a paternalistic approach when reviewing projects that propose to interview those who have been deemed ‘mentally ill’. Holland describes the ethics review feedback on her own proposed research regarding mental health, which questioned her qualifications as a humanities-based scholar and detailed concerns about her and her supervisory committee’s lack of clinical training. The ethics board was also concerned about whether or not participants could be considered “well enough” to participate in her project

(Holland, 2007, p. 901). She contends that this concern raises questions about the definition of 'well enough' and who gets to decide whether or not a participant qualifies as such. As Holland states, "The concept of 'well enough' is difficult to define and third-party judgments of 'well enough' potentially could be based on anything from perceiving people as too vulnerable, too emotional, too angry, too resistant, too passive, or too much of a threat to the researcher" (p. 901).

Holland (2007) also points to the contested nature of mental illness and the failure of ethics boards in recognizing this and understanding the mad as those who have been medicalized rather than as patients (p. 900). She concludes that questioning the ability of those who have been deemed mentally ill to consent to participate in social research is in fact a violation of human rights and that ethics boards need not assume that ethical problems are present solely because of a medical diagnosis of mental illness (Holland, 2007, p. 910). Though I did not encounter the kinds of problems Holland describes during the ethics review process at York University, I believe that the aforementioned comments from a participant's friend reflect the kind of attitudes she describes and highlights a significant issue in thinking through ethics in relation to my project.

This also highlights what I see as one of the contributions of my project: that it approaches the study of mental health from a social science perspective. The fact that I am not using a positivist, medicalized approach may indeed have been part of what enticed some interviewees to participate in my project. Many participants expressed a dislike for the paternalistic and pathologizing ways in which they had been treated by medical professionals. As a researcher coming from outside of medicine or psychology, I may have inspired more trust in some participants rather than less. For some participants,

especially those who have had negative experiences at the hands of clinicians and medical professionals, my project was something they wanted to contribute to precisely because it offers ways of understanding mental health outside of a medicalized context.

In this chapter I critically reviewed some of the literature that I consider to be a part of mad studies. I looked at historical work regarding madness, focusing on the ways that knowledge production about madness is racialized, sexualized, and gendered. This historiography showed how conceptions of madness change over time and how elite discourses have shaped dominant worldviews about madness. I then outlined more contemporary critiques of psychiatry from anti-psychiatry studies, gay and lesbian studies, queer studies, and trans studies in order to discuss the impact of dominant discourses of madness on those considered mad. In outlining these critiques I showed the ways that anti-psychiatry and gay and lesbian studies, queer studies, and trans studies could usefully inform one another. I argued that anti-psychiatry has made important interventions, but has neglected the voices of racialized, queer, and trans people. Likewise, in the rush to critique the ways that LGBTQ people have been pathologized by psychiatric diagnoses, gay and lesbian studies, queer studies, and trans studies have failed to take up the other ways that concept of ‘mental illness’ plays a role in the lives of LGBTQ people.

I then discussed the methodological decisions regarding this project, emphasizing the importance of the inclusion of mad people’s voices through my chosen method of qualitative interviewing. I also discussed the recruitment of participants and the terminology regarding sexuality, gender, and madness. I concluded with an exploration of

some of the relevant ethical considerations, demonstrating the value of a social sciences approach in understanding madness.

Chapter Two: Making Sense of Madness: Social Approaches to Lesbian, Gay, Bisexual, Queer, and Trans Experiences of Mental Distress

In the last chapter I outlined some of the literature in mad studies that highlights the socially constructed character of madness, the gendered, sexualized, and racialized nature of knowledge production about mental distress, and the negative impact of psychiatric practices on mad people. I also examined scholarly work in queer studies and trans studies regarding the problematic pathologizing of non-normative sexualities and gender identities. I argued that while these bodies of literature have made important interventions, anti-psychiatry studies fails to specifically address the psychiatrization of lesbian, gay, bisexual, queer, and trans (LGBTQ) and racialized people, while queer and trans studies tends to reflect ableist beliefs about madness and focuses on specific diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM) such as homosexuality and gender identity disorder (GID). These attempts to ‘rescue’ LGBTQ people from the categorization of madness and the accompanying discrimination associated with being considered ‘mentally ill’ leaves the biomedical model and all of its attending problems intact. Homosexuality and GID are not the only diagnoses that affect queer and trans people, and some of the critiques of these diagnoses can in fact further alienate LGBTQ people who experience mental distress.

How, then, do we discuss specific issues regarding the psychiatrization of LGBTQ people without falling prey to ableist ideologies? How do we critique the pathologizing of LGBTQ people while avoiding the pitfalls of dichotomous thinking that reinforces the sane/insane binary as well as the oppression associated with being mad? In this chapter I argue that advancing a broader critique of the biomedical model as a whole while paying special attention to the ways in which it specifically affects LGBTQ people

can provide a more comprehensive understanding of the issues facing LGBTQ people who experience mental distress. The purpose is to understand experiences of madness by locating them within social contexts, rather than simply attributing them to individualized pathologies. This is particularly salient for LGBTQ people, who as members of marginalized groups often experience distress related to homophobia, transphobia, and other forms of oppression. This chapter is therefore simultaneously a critique of the biomedical model of mental illness and an argument for the use of social approaches to make sense of LGBTQ experiences of mental distress.

I begin with brief descriptions of the biomedical model of mental illness and social approaches to mental distress. I then outline some of the main critiques of the biomedical model articulated by my study participants in their explanations regarding their dis/identifications with various terminologies related to madness. In some cases, these critiques also clearly point to the usefulness of social approaches to mental distress as a way to explain their experiences. I then turn to a discussion of psychiatric diagnosis as a way of making sense of mental distress in order to further explicate the limitations of the biomedical model of mental illness. Finally, I present some of the social factors identified by the participants that played a role in their experiences of mental distress, arguing that social approaches render these experiences more fully intelligible.

Making oneself intelligible: The importance of language

Discussions about mental distress are overdetermined by biomedical model frameworks and discourses. I am reminded of this every time I describe my research to someone new, both within and outside of academic settings. Inevitably I am met with questions or comments about my research regarding ‘mental illness’ or my study

population of ‘mentally ill’ participants. Despite my best efforts, I have yet to find a way to explain succinctly that my research is not about ‘mental illness’ and ‘the mentally ill.’ This speaks to the success of the biomedical model in pervading and dominating both academic and mainstream consciousness. It also indicates the importance of language in structuring frameworks of intelligibility.

Many scholars who theorize social approaches to understanding mental distress underscore the importance of language in this endeavour (Boyle, 2011; Johnstone, 2006; Tew, 2005; Tew, 2011). As Boyle (2011) contends, “linguistic devices” are crucial in foregrounding social context, and it will be difficult to do this “without entirely abandoning medical language, including the term ‘mental health,’ because using this language is the quickest and most effective way of implying lack of intelligibility and suggesting a pathological or deficient individual” (p. 41). Boyle is referring here to mental health practitioners and researchers and acknowledges that this will be a difficult task given the predominance of “context-free and context-lite language” (p.41). It is perhaps even more difficult for those who are medicalized and at a power disadvantage to insist on an alternative language. Yet many participants did indicate resistance to biomedical terminology and perspectives. It is therefore important to explore the different implications and possibilities that arise when biomedical model language is challenged or rejected.

This challenge is not simply a matter of semantics. As Beresford (2002) argues, “the interest of mental health service users/survivors in exploring difference conceptual frameworks and approaches has become visible through their development of a different language, which replaces the idea of ‘mental illness’ with terms like ‘madness’ and

‘mental distress’” (p. 582). This chapter will therefore draw on the conversations I had with participants about their dis/identifications with various terms, identities, and diagnostic categories. However, this is not simply a discussion of the different ways in which participants self-identified. As will be seen, the participants’ rationales for rejecting or embracing various terminologies often pointed to some of the fundamental problems with the biomedical model itself and indicated the value of social approaches to mental distress.

The ways in which participants discussed these matters indicates that language use and identity formation is complex and sometimes seemingly contradictory. For example, even those who spoke about rejecting medicalized ways of understanding themselves often used diagnostic categories to make parts of their experience intelligible. Again, this exemplifies the difficulties of talking about mental distress in a way that it is not medicalized. In some cases, this was due to the permeation of diagnostic terms into colloquial language, such as ‘depression’ and ‘anxiety.’ For example, Esther, a white, queer, cisgender woman in Winnipeg, said that she does not “trust the medical system very much” and so does not “really identify with most of the terms that are coming out of that system.” She had “read a little bit about anxiety disorders and always felt like those didn’t apply,” yet she needed a name for what she was experiencing. As she said, ‘anxiety’ “was the closest one that I could find, without actually doing a whole lot of research or asking of hard questions. It’s also a mild word compared to some other words.” When I asked her what she meant by ‘a mild word,’ she replied, “I feel like that word gets used a lot. People will say ‘I’m feeling anxious’ or ‘there was a lot of anxiety in the room at that event’ or things like that. And so it’s a word that gets used in everyday

conversation a lot. And maybe for that reason it doesn't have as much heaviness." As Esther's comments also indicate, diagnostic categories can provide a shorthand way of 'making sense' of sets of experiences, thoughts, or behaviours that do not have other readily available names, even when the participant does not 'put much stock' in the legitimacy of such categorizations.⁹ This is indicative of the ways in which ideologies that can be theorized as discrete are not necessarily experienced as such in everyday life. For the sake of coherency, I therefore very loosely refer to participants as those who make use of medicalized frameworks to understand themselves and those who challenge such perspectives based on whether or not this was mostly the case. However, the reader should bear in mind that most participants demonstrated an overlapping mixture of ideologies in their narratives and that participants' perspectives and identities are not static and shift over the course of time. Moreover, while I expected that there might be some strong differences in terms of how participants identified given the presence of mad activist groups in Toronto and the lack of such groups in Winnipeg, this was not the case, perhaps because none of the participants were involved in mad activism. I therefore do not make distinctions between the Toronto and Winnipeg groups.

The biomedical model of mental illness

Despite the prevalence of the biomedical model of mental illness, there may be some confusion as to the specifics of what is being referred to. Lewis (2006) describes the main tenets of this model as follows: 'mental illness' is a disabling, biological deficiency that is "accompanied by physical pathology," and can be "classified as distinct disorders that have characteristic common features" (p. 107). Further, the causes of

⁹ The reader will note that I do not identify participants using diagnostic categories to avoid legitimizing medicalized perspectives as 'the truth' about the participants' experiences and identities.

‘mental illness’ can be explained “in terms of physical illness” such as brain structure, genetics and biochemistry (Lewis, 2006, p. 107). While psychiatry, as a medical science, is most obviously informed by biomedicalism, this perspective also extends to psychology. As Rapley, Moncrieff, and Dillon (2011) state, “Mainstream psychology...while sometimes appearing to offer alternative approaches, essentially supports the positivist psychiatric project of codifying human suffering into disease-like categories” (p. 1). There are versions of psychiatry and psychology that place more emphasis on social context, but as Beresford (2005) claims, even these “have taken as given the over-arching medicalized framework of ‘mental illness’, although differing in the extent to which they saw it as a consequence of nature or nurture” (p. 36). The same claim has been made about social work practice and education (Poole et al 2012). Seemingly ubiquitous, the biomedical view of mental illness extends well beyond formal medical contexts. It is evident in anti-stigma campaigns that compare ‘mental illness’ to a ‘disease like any other,’ in news stories that attribute violent behaviour to ‘mentally ill’ perpetrators, and in television shows like *Mental* (2009) and *Cracked* (2013) and blockbuster movies such as *A Beautiful Mind* (2001) and *Black Swan* (2010). Therefore, when I refer to the biomedical model of mental illness, I am invoking a concept much larger than simply that which forms the basis of the medical practice of psychiatry.

As other scholars have argued, there is inadequate evidence to support biomedical explanations of ‘mental disorder,’ yet it remains the predominant framework (Beresford, 2002; Johnstone, 2006; Rapley, Moncrieff, & Dillon, 2011; Tew, 2011). As Lewis (2006) contends, there are any number of problems with the biomedical model of mental illness, including the ways it serves to “naturalize and reify ‘mental illness,’” perpetuates the

“medicalization of deviance,” upholds “psychiatry as an agent of normalization, state control, and multicultural oppression,” supports the pharmaceutical industry, and precludes the use of multiple approaches to understanding madness (p. 109). Perhaps one of the most significant problems is that ‘service users’ find it largely unhelpful (Beresford, Nettle, & Perring, 2010).

One of the biggest challenges to the veracity of the biomedical model of mental illness is the lack of identifiable causal biological factors. Diagnosis of any illness is based on “clusters of symptoms” (subjective complaints such as fatigue, inability to concentrate) as well as “signs such as measures of blood sugar, white cell blood counts...which are objectively verifiable by others” (Johnstone, 2006, p. 85). As Johnstone (2006) and others have pointed out, such objective ‘signs’ or measures do not exist when it comes to psychiatric illnesses. Further, the diagnostic criterion (for example “flat affect” or “peculiar behaviour”) outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) are largely “examples of beliefs, experiences and behaviour” rather than “complaints about bodily functioning,” making them subjective judgments based on social expectations and norms (Johnstone, 2006, p. 85). As Johnstone (2006) states, “It is relatively simple, in principle, to work out how the body ought and ought not to function, it is an entirely different matter to decide how people ought and ought not to think, feel and behave” (p. 85). Johnstone’s observations point to the obviously enculturated character of psychiatric diagnosis and the problems with positioning ‘mental illness’ as an ‘illness like any other.’

There is a critique to be made of Johnstone’s claim that scientific judgments about bodily function are objective and free from the influence of social norms. Following

Khun, (1962) amongst others, a larger case could be made for addressing the enculturated character of science, medicine, and the biomedical model more generally. One could argue that there is no such thing as ‘objectivity’ in the positivist sense and that biological ‘signs’ or measures for physical illnesses are interpreted and made sense of through social and cultural norms. This critique is made on different, though interrelated, grounds; the enculturated character of supposedly objective biological measures as opposed to the lack of such measures altogether. As I have already described, the ‘objective’ signs or measures of mental illness do not exist and diagnoses are therefore based on criterion more widely agreed upon to be ‘subjective.’ While this should, in theory, make it more vulnerable to critique, the biomedical model of mental illness has thus far proved itself to be remarkably tenacious and pervasive. To allow for a detailed, in depth critique, my focus is on biomedical and social approaches to mental distress; a critique of the biomedical model more generally is beyond the scope of this dissertation.

Social approaches to mental distress

The limitations of the biomedical model have led some to call for social approaches to understanding madness (Ballou and Brown, 2002; Beresford, 2002; Bracken et al. 2012; Carr, 2005; Johnstone, 2006, Rapley, Moncrieff, & Dillon, 2011; Tew, 2006). Social approaches are multidisciplinary and reflect many different perspectives. Tew (2006) argues that the goal is not to create “one singular and internally consistent ‘social model,’” but rather to honour “complexity and diversity of experience” through the development of a multiplicity of social perspectives (p. 16). However, he contends that social approaches share the following main tenets: normalizing experiences of mental distress by challenging dichotomous thinking that categorizes people as either

‘normal’ or ‘mentally ill,’ taking into account the social contexts related to people’s experiences of madness, respecting and legitimizing people’s accounts of their own experiences, and using anti-oppressive principles that consider power, discrimination, and oppression. Furthermore, social approaches foreground agency and position those experiencing mental distress as active and capable of making decisions about their own lives (pp. 16-18).

The literature emphasizing social approaches to mental distress tends to remain at a theoretical level or in some cases is based on the authors’ experience as mental health care practitioners. Social frameworks value the perspectives of those who experience mental distress and social research is well poised to gain access to these perspectives. These approaches are also particularly useful for making sense of LGBTQ experiences because of the focus on power relations and oppression. However, there are few social approaches that specifically address the experiences of LGBTQ people in a comprehensive manner. This chapter will begin to address these gaps, though it is not meant to offer a proscriptive or rigid framework.

The biomedical model as a deficit model: Insights from disability studies

Social approaches to mental distress have roots in disability studies and activism (Beresford, 2004). The social model of disability made key interventions by challenging the positioning of disabled bodies as deficient and in need of repair (Barton, 1996; Drake, 1999). Social theorists of disability have critiqued the biological essentialism inherent in the biomedical model, which “focuses on physical difference” and defines disabled people “as that group of people whose bodies do not work; or look different or act differently; or who cannot do productive work” (Shakespeare, 1996a, p. 95). Disability

theorists and activists have also challenged oppressive beliefs concerning disabled people. Social model theorists accomplish this by defining ‘impairment’ as an embodied state and ‘disability’ as a product of the way in which society is constructed to exclude people with disabilities through the built environment and social attitudes (Barnes et al., 1999; Oliver, 1990; Oliver, 1995). Scholars and activists have also countered the positioning of disabled people as tragic, pitiable victims with pride about disabled identities and embodiments (Butler & Bowlby, 1997).

The social model of disability focuses primarily on physical disabilities and was not developed in ways that address experiences of madness and mental distress (Beresford, 2004). It is therefore not directly applicable to conceptualizing madness. Perhaps one of the most significant limitations is the conceptualizing of impairment, which has been critiqued for a number of reasons, including the ways that it replicates the biological essentialism of the biomedical model (Shakespeare & Watson, 2002). As Beresford and Wallcraft (1997) point out, many who experience mental distress do not identify as having an impairment or a disability and associate this idea with “the medicalization of their distress” (p. 67). This was particularly salient for my study because the participants were not unanimous in identifying their mental distress as a disability. When asked whether or not they characterized their mental health status as a disability, 38% (14) responded yes, 38% (14) responded no, 19% (7) said they did sometimes or had in the past, and 5% (2) were unsure.

However, there are some insights from disability studies that are applicable to understanding mental distress, particularly the critique of the biomedical model as a deficit model. The deficit model ideology was especially apparent in the narratives of

those who made use of biomedical model approaches to understand their bodies and experiences. For example, Lisa, a white, Portuguese, French-Canadian, lesbian, queer person in Winnipeg described herself in the following way: “Borderline [personality disorder] is fifty percent neurosis and fifty percent psychosis. So there is wiring wrong with my brain and then the rest of it is learning the wrong way.” Another participant, Mary, a racialized, queer, cisgender woman in Toronto said, “I do identify as [mentally ill], but I’m not ready to, if that makes any sense. I feel that it has so much negativity with it, like, you know, not able and not healthy and not like normal enough that it kind of scares me.” While Mary feels that she ‘should’ define herself as mentally ill, she is reluctant because of the underlying ideologies about abnormality and deficiency and the ways that this affects her self-concept as well as the ways that others may perceive her.

For those who reject medicalized language, part of what they reject is this underlying ideology of being somehow defective or deficient. As Aaron, a racialized, gay, cisgender man in Toronto said about a friend who identifies as mentally ill, “It’s really disabling and limiting to identify as someone that’s mentally ill because I feel like it informs his ideas of what’s possible, his ideas of how well he can do and it makes it really limiting.” Similarly, Caleb, a white, bisexual, trans man in Toronto indicated that adopting ‘mentally ill’ as an identity would position his “head space” as “being in need of repair.” Furthermore, he believes that “it’s really easy to be stigmatized if you’re describing yourself as mentally ill.” Caleb rejects the term ‘mentally ill’ as an identity because it suggests that there is something wrong that needs ‘curing.’ As his comments also suggest, this has an effect on his self-understanding as well as the way he is

perceived by others, as the biomedical model is profoundly linked with the widespread ‘stigma’ or discriminatory beliefs regarding ‘mental illness.’

Indeed, disability studies scholars have shown how the biomedical model construction of disability encourages oppressive views of people with disabilities by positioning them as inherently, biologically inferior people in need of ‘correction’ (Barton, 1996; Drake, 1999). While ‘stigma’ is not limited to the biomedical model, this framework does encourage the ‘othering’ of those experiencing mental distress. Theorists of social approaches to mental distress have also taken this up. As Fernando (2010) argues, “psychiatric stigma may not be unavoidable in a context where a biomedical model of illness predominates but may be extremely difficult to counteract given the way in which the model is interpreted in society today” (p. 39). As he states about the way the diagnosis of schizophrenia is interpreted, it is “associated with dangerousness, violence, confusion and, more than anything else, alienness that renders people afflicted with it as being beyond understanding, irrational and bizarre; that is the way they are” (p.39). He therefore believes that the way to combat stigma is to abolish the biomedical model.

Indeed, as will be discussed in more detail later on in this chapter, the biomedical model is based on a problematic mad/sane dichotomy, positioning those who are deemed ‘mentally ill’ as naturally ‘disordered.’ As Read and Haslam (2004) contend, this essentialist and dichotomizing approach is deeply problematic. As they state,

Believing in immutability may promote pessimism and avoidance. Believing in a biological essence promotes the view that the disorder represents uncontrollable, untamed nature. Believing in discreteness promotes the view that sufferers are

categorically different, rather than sharing in our common humanity. These essentialist beliefs form a toxic ensemble (p. 141).

Naming this toxic ensemble ‘stigma,’ however, does not do it justice. ‘Stigma,’ a term used to indicate a belief system that denigrates ‘mental illness’ and those deemed ‘mentally ill,’ might more aptly be called sanism and discrimination. As White (2009) argues, the concept of ‘anti-stigma’ is often used in such a way as to reinforce rather than challenge “dominant representations of madness as a disease, and of mental illness as a national (social, political and economic) problem” (p. 1) through focusing on “deviance and stigma” as opposed to “human rights and discrimination” (p. 5). Likewise, Kanani (2012) argues that “focusing on stigma” can obscure “relevant structural power dynamics” such as the structural racism that “shapes many people’s encounters with medical and psychiatric institutions” (p. 1). In other words, the concept of stigma is often used in the service of the biomedical model of mental illness, sidestepping social and structural processes that marginalize those considered ‘mentally ill.’ For these reasons I henceforth use the terms ‘sanism’ and ‘discrimination,’ though some participants used the word ‘stigma’ to describe their experiences.

The negative impact of sanism was evident in most participants’ narratives, and self-directed or internalized sanism was particularly evident in the narratives of those who did not question medicalized approaches. One such participant, Barb, a white, lesbian in Winnipeg said,

It just needs to be elevated to be not so much of a stigma. Because lots of times you don’t want to admit it because it’s embarrassing. The counsellors will say

‘don’t say that’ but it shows weakness, I think. These are things that I’ve felt, that it shows weakness or that you’re lesser.

Similarly, Crabitha, a Métis, lesbian, cisgender woman told me, “in terms of how I identify with myself, I would say I consider myself damaged,” which she defines as “feeling like there’s something really wrong with you deep inside that other people don’t have.” Barb and Crabitha have internalized the ideas inherent in the biomedical model that they are defective and inferior.

For some participants, this was a reason not to identify as ‘mentally ill’ even if they saw themselves as such and used a medicalized approach to understanding themselves. As Lisa, quoted above, said,

I’m definitely mentally ill but I don’t call myself that because I don’t want to see myself as sick. I tell people I have issues [laughs] and they understand that.

People accept that easier. If I say I have a mental illness they automatically think I’m crazy. You say ‘mental illness,’ too, they won’t necessarily take you seriously.

You say ‘issues’ they understand that it could be a range of things anywhere from physical to mental, which is kind of accepted.

Lisa avoided using the term ‘mentally ill’ even though she sees herself as such because it is a term that is so heavily steeped in sanism. She was concerned about the ways in which she would be perceived by others if she were to identify as ‘mentally ill.’ Like Lisa, many participants were concerned that they would be reduced to their diagnosis and perceived as incapable by others if they identified as ‘mentally ill.’

While internalized sanism was not necessarily limited to participants who accepted the biomedical model, those who critiqued it often also articulated some

resistance to sanism. This is consonant with Schrader, Jones, and Shattell's (2013) claim that those who claim a politicized identity are "more likely to resist internalizing public stigma" (p. 63). As will be discussed in more detail throughout this chapter, social approaches understand mental distress as a non-pathological part of human experience. Perhaps those who held such beliefs were better equipped to resist oppressive beliefs that position them as pathological 'others.'

Challenging the mind/body dichotomy and embracing a more holistic approach

Participants who rejected medicalized language often critiqued the biomedical model's approach to understanding the mind as distinct from the body. As Porter (2002) argues, the mind/body dualism is characteristic of Western medicine and positions 'mental illness' as a distinct phenomenon from 'physical illness.' Betty, a white, cisgender, queer woman in Winnipeg described the reasons that she does not trust psychiatric approaches to 'mental illness' as based on a critique of this dichotomy. As she said,

We separate brain and body and it's stupid. It makes no frigging sense at all. Because of that I don't trust people because I think that is a big fucking mistake. And it's a lie, also. You can't separate those two things. So having people committed to an entire industry where that's what they do, I'm like, 'your entire freaking practice is based on bullshit so how am I really supposed to trust that much of what you have to say?' It's the same problems that I have with the mainstream Western medical model.

For Betty, as for other participants, the belief in the mind and body as distinct casts doubt on the veracity of psychiatric ideologies and practices. Similarly, Esther, quoted above, said:

All the aspects of my being are really inter-connected and it's impossible to separate them into one issue or one piece of myself that can be sick while the others are not or vice versa. So 'mentally ill' is problematic for me in that sense, because that implies that there isn't that inter-connection.

Esther does not define herself as 'mentally ill' because it implies that mental and physical health are mutually exclusive. Another participant, Viki, a racialized, queer, gender-fluid woman in Toronto, explained how this ideology is problematic for making sense of her experiences:

If your mind is unwell, that can take a toll on your body in lots of ways. Stress can weaken your immune system. But also if you're in a bad emotional mental place, then you can also not take care of your body in the way that you normally would. And that has an impact on your physical health. For me personally I have PTSD [post-traumatic stress disorder] and my seizures are very much a unification of the two because trauma and certain situations and stress trigger a physical manifestation. And I don't really understand how that happens and the doctors don't either. But I see them as together.

Viki explained how her experiences of mental distress are intimately connected to a physical manifestation that takes the form of seizures. Indeed, as Rogers and Pilgrim (2010) contend, there is a direct link between mental distress and what is characterized as 'physical' ill-health. They state, "Physical disturbances can sometimes produce profound

psychological disturbances. Given that emotional distress has a well-established causative role in a variety of psychosomatic illnesses, like gastric ulcers and cardiovascular disease, the mutual inter-play of mind and body seems to be indicated on reasonable grounds” (Rogers and Pilgrim, 2010, p. 3). As Mike, a white, omnisexual trans man in Toronto described, the term ‘mentally ill’ implies that this cannot be the case:

Oh, mentally ill. Oh, well, I hate that one. Because that just says that some people are healthy and some people are ill and I’m one of the ill people. And mental health is separate from physical health and it’s, you know, I have mental problems. Yeah, so that one does not sit well with me. It sounds like something that a doctor would call a patient in a not-helpful way.

Mike succinctly summarizes a number of issues with the term ‘mentally ill,’ including the implied mind/body binary, as well as the problematic mad/sane dualism and the power of health care professionals to define the experiences of others, points which will be revisited later in this chapter.

Resisting the pathologization of marginalized groups

Those who refused to take on the label ‘mentally ill’ often did so on the basis of resisting the pathologization of marginalized groups. For example, Brock, a white, gay, cisgender man in Winnipeg pointed to how medicalized language can be used to label the behaviour of marginalized people:

I am averse to using ‘mentally ill’ as a descriptor. Especially because it’s so ambiguous. You know, I use the example of a woman who’s homeless on the street begging for money... , kind of mumbling to herself and rocking back and forth and not making eye contact with anyone. And then you have down the street

a man coming, dressed sharp....who steps over her... , looks at her, scoffs ‘get a job’ and continues to walk away. Who is mentally ill? It’s such a weird term that someone who shows signs of ‘mental health problems,’ and then you have someone who can be so cruel when they have the means to offer maybe an iota of support.

Brock rejects the label ‘mentally ill’ because it is often applied to those who engage in behaviour that is perceived to be morally reprehensible, which as Brock’s comments indicate is a subjective judgment based on social values that tends to target the marginalized. He therefore does not refer to himself using medicalized terms and has chosen to call himself a “mad man with a box.” Brock describes having the freedom to challenge medicalized language and create alternatives as part of his privilege as a young white man living in the global North:

I’m a twenty-year old white male living in North America, I’m the least oppressed person on the continent, so it kind of plays to my benefit to challenge stereotypes and archetypes. And it’s almost my duty, it’s all of our duty if we’re able, to rise up and fight oppression systematically and institutionally.

Brock feels that his privilege gives him the freedom and obligation to challenge oppressive beliefs.

Conversely, some participants had a heightened awareness of the possible negative effects of pathologization based on their experiences with oppression. For example, Laila, a racialized, queer, cisgender woman in Toronto, explained that as a teenager, she tried to avoid being psychiatrized at all costs. She told me that she had experienced the many “stereotypes of brown people and brown fathers especially” that

characterize “young brown girls” as “victims of this patriarch.” Laila was asked by counsellors to “validate this narrative” and feared that her behaviours would be categorized as symptomatic of ‘mental illness’ and would validate racist stereotypes about her family. As she said,

It would have torn into my family. It would have made it very difficult for us to continue the way that we were.... To feed into this idea of this patriarchal brown male with young daughters would have been really hard. That’s why I wouldn’t talk about any of these things and I was aware enough to hide the things that I was doing.

Laila’s experiences point to the problematic pathologizing of racialized people that is characteristic of the biomedical model. As Fernando (2010) contends, psychiatric practices are enculturated and are thus implicated in perpetuating racism. As he states, “Political, social and ideological pressures current in society always impinge on the diagnostic process by influencing questions of intelligibility, common sense, clinical opinion, pragmatism and tradition. And racism acts through these pressures” (p. 68). Laila therefore rejected medicalized terms. In response to my questions as to why, she responded:

Well [laughs] because they’re fucked up. Why do I reject them? Because they are socially constructed and they are used to discipline people and regulate people and especially people who are located in certain spaces or have other experiences of oppression as well. So it’s pathologization of certain behaviours used to govern people. That’s why I feel I can’t accept that language.

Laila draws attention to the ways in which medicalized terms are not ‘just words’ but reflect underlying ideologies that can be used as tools of social control, targeting marginalized groups in particular. She was successful in avoiding the psychiatric system and the forceful application of labels such as ‘mentally ill.’ For this reason, she also does not use any reclamatory terms like ‘psychiatric survivor’ or indeed, as she put it, “any identity-based categories related to mental health or madness.” Instead, she simply states: “I guess the closest I would come would just be to say that I relate to madness without necessarily taking it on.”

Trans participants also had experience with the effects of pathologization and were therefore often critical of the biomedical model and its terminology. For example, Caleb, quoted above, said:

‘Mentally ill,’ I don’t know if I’ve ever actually considered that as something that I would use to describe myself.... I don’t ever really want to define myself as ‘ill.’ That’s just another way to pathologize myself in a way that doesn’t feel comfy and fun like ‘crazy’ sometimes.

Caleb implicitly suggests that he is already familiar with (and rejects) the negative effects of internalizing pathologization, (“just another way to pathologize myself”) perhaps on the basis of sexuality and gender identity. He calls himself a ‘psychiatric survivor’ in order to indicate “the abuses I’ve had at hand of the system and how I’ve survived that instead of just kind of pinning myself with a very pathologized idea.”

Likewise, Smith, a white, queer, trans man in Toronto, likened his rejection of the term ‘mentally ill’ to his rejection of the pathologization of his trans identity. He said that while others would label him as ‘mentally ill,’ he does not take on this label:

Similar to not feeling wrong about being trans, I don't feel ill. You know, I feel like I have hard things that happen in my life, but so does everybody else and so it's a process of trying not to minimize that but also finding what works for me and I am really wary of psychiatric avenues.

Smith has managed to avoid psychiatric services for many years and therefore also does not take on terms such as 'psychiatric survivor' or 'psychiatric service user.' The term he chooses to self-identify with is 'pervert':

It's something that's been applied to queer and trans folks for a really long time. And then to add the element of being kinky into that is interesting because I feel like it's really normalized within queer communities, but when I think about it outside of that, most people would consider how I live my life and do my relationships and sex to be really perverted. But I also kind of enjoy that. That's part of being queer for me, is being something that's really unpalatable to heteronormative society. I feel like I gain a lot of power from that label. It feels like part of a big 'fuck you' to standards of what relationships and sex should look like.

Smith reclaims 'pervert,' a term that has its origins in medicine, as a way to pathologize non-normative sexualities, genders, desires, and behaviours, and in doing so also resists the positioning of gender and sexual dissidence as illness.

Challenging the sane/insane binary

Smith's comments about the everyday nature of distress also challenge the distinction that is generally made between those who are mad and those who are sane. Attempts at understanding mental distress as a part of everyday life experienced by many

people challenges one of the fundamental characteristics of the biomedical model: the dichotomous categorizing of people as either ‘sane’ or ‘mentally ill.’ A critique of the binary distinction between mad and sane and the pathologizing of the mad that accompanies this dichotomy is common amongst scholars seeking other ways to conceptualize madness.

For example, Bentall (2003) argues that “the ‘us’ and ‘them’ distinction has had a number of very serious negative consequences for those living at the mad end of this spectrum,” including the suppression of the voices of those deemed mad, harmful medical ‘treatments’ such as insulin induced comas, electroshock therapy, leucotomy, and in the case of Nazi Germany, mass extermination” (p. 496). According to Bentall, the evidence shows that “we are mad to varying degrees, that the boundaries of madness are subject to negotiation, and that some of us get on very well despite being (in psychiatric terms) quite psychotic for much of the time” (p. 496).

Many of the participants reflected this view in their explanations of why they did not identify with the term ‘mentally ill.’ For example, Rob, a white, queer, gay, cisgender man in Winnipeg depathologized his experiences of depression and anxiety, stating that he does not describe himself as ‘mentally ill’ because he thinks of his mental health as “not being perfect but as par for the course” because “a lot of people deal with depression, whether it’s acute or temporary or long-term.” Another participant, Allison, a Torontonians who identifies as white, queer, and genderqueer, told me that she does not use the terms ‘mentally ill’ or ‘mad’ because they both carry “a lot of stigma.” She also rejects these terms because:

While there might be things that I deal with on a daily basis, they don't define me. And I don't see them as ruling my life. I like to look at it as something like, 'okay I'm dealing with this,' basically. So that's why I would probably choose to go for 'psychiatric service consumer.'

Likewise, Aaron, quoted above, also saw 'mad' and 'mentally ill' as pathologizing terms that reinforce the mad/sane dichotomy.¹⁰ He said that he did not identify with 'mad' "because of the historical connotations." He elaborated and said:

It seems like a word to describe violent, angry, uncontrollable people, which is really marginalizing. If you have psychological issues to call someone 'mad' or label them 'mentally ill' I feel like it isolates them. And it's something that they need to be quarantined and dealt with for. So I'm not sure if I agree with the use of those words.

Aaron points to the way in which labeling someone based on a binary understanding can be dehumanizing and marginalizing. He therefore does not take on any identity-based terms regarding mental distress and simply describes his "mental health" as "ambivalent at best."

Challenging the mad/sane binary, which is characteristic of the biomedical model, may cause some concern about sliding in to an unhelpfully relativist position on how to understand these concepts. It is important to note that this challenge is not the same as claiming that 'mental illness' does not exist. The argument is that experiences of mental distress exist, but the biomedical model is an unhelpful way of 'making sense' of those experiences. The next section will further clarify why this is the case.

¹⁰ Allison and Aaron's comments also indicate that the term 'mad' was not always seen by the participants as a non-medicalized term and was sometimes interpreted as akin to 'mentally ill.'

Making sense of mental distress through psychiatric diagnosis

Theorists of social approaches to mental distress have challenged the scientific validity of diagnostic categorizations. Many have pointed to the fact that psychiatric disorders have no “construct validity,” which means that no underlying biological or “causal pathological mechanism” has been identified (Thomas, 2013, para. 3-4). Further, psychiatric diagnoses have no “predictive validity,” meaning they do not offer an accurate depiction of “a specific course and outcome” (Thomas, 2013, para. 3-4). Some have pointed to the ever growing roster of psychiatric diagnoses pathologizing an increasingly large list of behaviours, emotions, and experiences of distress, leading to questions about whether any one could be deemed mentally healthy (Davis, 1997; Mosher & Boyle, n.d.; Rapley, 2012). Even a brief look through the most recent DSM may reasonably lead some to conclude that this is indeed the case. Boyle (2007) contends that diagnostic categories do not realistically describe real life behaviour and emotions and that there is so much overlap between diagnoses that in some cases there may be little similarity between people who share a diagnosis (p. 290). Many contend that the evidence overwhelmingly points to mental distress as an understandable response to adverse life experiences and thus suggest that diagnostic categorization should be abolished altogether (Bentall, 2003; Boyle, 2007; Kinderman, Read, Moncrieff, & Bentall, 2013; May, 2007; Tew, 2011; Thomas, 2013).

However, these debates tend to remain at the theoretical level and do not examine how people actually experience the diagnostic process (May, 2007; Tucker, 2009). As May (2007) argues, the process of receiving a psychiatric diagnosis transforms distress into a medicalized, individualized problem. Being given a diagnosis can have a huge

impact on identity and experience. As Tucker (2009) contends, diagnosis is a form of social recognition with many negative associations, and has the “power to form identities that exist across multiple contexts...and become the prime identifying feature” (p. 4). Indeed, as one participant, Michelle, a white, queer, cisgender woman in Toronto said about her diagnosis, “I find that it’s a huge part of my identity.... I often feel like that’s a bigger part of my identity than my gay identity. I feel like that one, it comes first.... It’s kind of my top layer of identity, I guess.” It is therefore important to examine how the participants negotiated the diagnostic process, as it reveals much about both the appeal of, and the problems with, the biomedical model as it is actually experienced. Psychiatric diagnoses are the predominant way of explaining experiences of madness, but the participants’ narratives reveal that there are few benefits and many problems with this method of making sense of mental distress.

The literature in social approaches to mental distress suggests that the limited value of a psychiatric diagnosis to those who receive one is in finding some kind of explanation for their distress (Boyle, 2007; Kinderman, Read, Moncrieff, & Bentall, 2013; Tucker, 2009). As Kinderman, Read, Moncrieff, and Bentall (2013) put it, “While some people find a name or a diagnostic label helpful, our contention is that this helpfulness results from a knowledge that their problems are recognized (in both sense of the word), understood, validated, explained (and explicable) and have some relief” (pp. 2-3). The participants’ narratives support this contention. For some participants, being given a diagnosis offered some relief in that they finally had a way to interpret behaviours, feelings, and thoughts that may have been scary and problematic. As Angela, a white, gay, cisgender woman in Winnipeg said about her diagnosis:

It helps explain a lot of my behaviours, too. So it's good to finally know that there was something wrong with me when I was [pauses]. Like I can recall having episodes when I was young but never identified or anything like that. So it kind of gives me comfort knowing that at least it's a condition that I do have. But unfortunately there's still a lot of people that really don't understand it.

Angela was able to take comfort in having an explanation for behaviour that had caused her problems throughout her life, even though she struggled with other people's lack of understanding of her experiences. Similarly, Barb, quoted above, told me it was "nice to have a definitive knowledge of what's wrong with you."

Ironically, participants often stated that being diagnosed with a mental illness was a relief because it meant that they were 'not crazy.' This underscores the extent to which 'crazy' has come to signify 'without reason,' irrationality, and unintelligibility. For example, Margaret, a white, bisexual, queer, cisgender woman in Toronto said, "It's kind of like, oh good, so it's something real, it's not just all in my head, it's not because I'm crazy, it's not just me." Similarly, Rob, quoted above, said it was "a relief" to be diagnosed:

It had been a while that I was kind of like, 'what the hell is going on, why do I feel this way.' So it was like, okay, at least I have sort of an answer to what this is and I'm not making it up. I'm not, it's funny [pauses] um, you know I was just about to say, 'I'm not crazy.' It's like, 'Oh I have depression, I'm not crazy' [laughs].

Though a psychiatric diagnosis often means that those diagnosed will in fact be perceived as 'crazy' by many, an explanation sometimes provided relief, even if only temporarily.

Essentially, mental health care professionals ‘made sense’ of behaviours, experiences, and thoughts that had become troublesome and provided some kind of ‘answer’ to what was feeling problematic.

The participants also expressed other powerful reasons for accepting biomedical explanations for their experiences. Many demonstrated that they were often encouraged to do so by family members and friends. Barb, quoted above, described this as follows:

I think I’ve come to accept it now. It’s been a long time. A couple of friends that have sat with me as I bawled and fought it and was angry and wanted to move past it, they sat there and said, ‘No, this is it. You’re probably going to have to take medication the rest of your life.’ You never see that for yourself, but I think there’s an acceptance of it now.

Barb describes an initial resistance to her diagnosis that she came to accept with the help of her friends. Barry, a white, gay, cisgender man in Winnipeg, described the impact of hearing his family members explain how they felt and how this seemed to explain his own experiences:

My mom has depression and so does my brother. They are on medication for it and they go see a psychiatrist. I didn’t realize until they were describing how they felt and I went, ‘Oh that’s really how I felt for two or three years.’ And I was like, ‘Oh well, I guess that was why I felt that way.’

Barry’s distress started to make sense to him within the framework used by his mother and brother. For many participants, the role of support networks was key in reinforcing diagnostic categorization as the best way to understand their experiences.

Participants who accepted their diagnoses as the truth about their experiences did not discuss aspects of the diagnoses that did not accurately describe them. Some, however, did express ambivalence about fully redefining their sense of self in accordance with the biomedical model. When I asked Mary, quoted above, about her relationship to her diagnoses, she told me that this was something she was “really trying to understand.” She explained this as follows:

There was kind of a stale point where I was diagnosed with depression until now with this new diagnosis and I wasn't on medication and I thought these fluctuations in mood were just my personality. I thought maybe I was just upset, like I just had bad coping skills with school or it was just part of the way that I was and I almost started to value [pauses], I mean I think I do still value, the days that are bad because I feel like they give me my personality. And they're valuable to me because that's what I have to offer. It's difficult for me to let go of it, for example with medication, because I feel like it's become so much a part of who I am. Now I'm trying to understand how my life can be, how I can be me as a person with mental illness versus someone who's trying to realign myself every day.

Mary was in the midst of grappling with a changing sense of self and hesitating to fully accept the medicalization of certain emotions and personality traits. Yet she felt strongly that her moods were more than just “a bad day” or “just stress” and that there was “something wrong” that the biomedical model of mental illness could explain and perhaps fix through psychiatric medication.

The hope that medical explanations could lead to resolving distress was common. As Crabitha, quoted above, said, “I can’t fight this problem if I don’t know what the problem is so I have to first of all identify what the issue is and then I can go about trying to fix it. You know, because I can’t keep going on the way I’m going.” As will be discussed more in the following chapter, treatments based on the biomedical model worked for some participants, providing another reason to accept their diagnoses as valid. As Beresford and Wallcraft (1997) point out, the biomedical model may also be the only framework they have ever encountered. As they state, “The idea of ‘mental illness’ is internalized. This is as a result of their broader socialization and passage through the psychiatric system. It is also likely to be the only analytical framework with which they are familiar for understanding their situation, feelings and perceptions” (Beresford & Wallcraft, 1997, p.70). Indeed, the dominance of the biomedical model can occlude other perspectives. Speed (2011) argues that it does not co-exist well with other ideologies. As he states, “If the service user draws from a medical discourse to explain their situation (invoking a chemical imbalance in the brain, for example, as the reason they have auditory hallucinations) then it becomes very difficult for that same person to blame, for example, poverty or abuse they experienced as a child” (p. 125).

It is also important to note that those who dispute the medicalization of their experiences or the veracity of their diagnosis are seen to be lacking ‘insight,’ a term that indicates that a person believes they are ‘sick’ and accepts a biomedical explanation for their ‘illness’ (Dillon, 2011, p. 153). Showing a lack of insight can be seen as “a cardinal feature of psychosis” (Bentall, 2003, p. 496). It can therefore be risky to disagree with

one's diagnosis, as this is itself seen as a sign of illness and can lead to further medicalization.

However, as the first half of this chapter demonstrates, some participants did not unequivocally accept medicalized explanations for their distress. Many expressed critiques of the diagnostic process and of diagnostic categorization as a way of interpreting their experiences. It is therefore important to examine how people who experience mental distress come to resist the disciplinary power of diagnosis. This discussion will also indicate some of the problems with diagnostic categorization as a way of making sense of mental distress.

Those who critiqued the biomedical model were less likely than those who did not to encounter alternative perspectives from family members and friends. Some discussed developing a critical sensibility in university and applying that lens to their understanding of diagnosis and biomedical frameworks. Devon, a white, queer, trans man in Toronto said he learned to question diagnosis and biomedical ways of thinking about madness “through education,” which led him to think of “medical or scientific discourse” as “failures”: “So I don’t see that as a solution anymore, as much as I would like to.” Devon indicates that he no longer has faith in psychiatry and diagnostic processes in part because of what he has learned in school. Likewise, Caleb, quoted above, said that “some of the most persuasive things and some of the things that guided me along to becoming comfortable with that term [psychiatric survivor] was really just my relationship with the things that I was reading in the academy.” Aaron, quoted above, explained that the more he learned about the DSM, the more he came to think that it is based on a “process that’s rooted in cultural conventions.” The result is that “I don’t trust diagnosis.” Aaron shifted

his understanding of diagnosis and madness from a biologically essentialist perspective to one that focuses on social and cultural factors through his learning in university:

It's been a process for me of learning about it because I always thought of myself as fairly, it was either I wasn't very smart or I wasn't very able, or I was just not good enough in terms of biology or mental make-up because I turned out gay. It was a long struggle and then the more I think about things I feel like it's more cultural, so I'm really interested in research into how shame is socially constructed and how violent shame and silencing can be.

Aaron points to how his learning helped him challenge internalized homophobic ideologies that position queer people as biologically and mentally deficient, which sparked an interest in social factors leading to mental distress.

Similarly, Laila, quoted above, said she was predisposed to critique biomedical explanations of mental distress because she “became a lot more political and a lot more aware of systems and power and oppression” through her experiences of being diagnosed with a physical disability. Laila was an undergraduate student in psychology at this time and began to look more closely at the studies presented in class:

What I started seeing was all these stereotypes built into diagnosing and labeling in the studies that we were reading about. Not everyone read through them in detail but I was the kind of person that would read these things, and methodology especially, and I saw how they were drawing diagnoses for certain things based on surveys of twenty white college students.

When Laila critiqued the methodology of these studies in her papers on these grounds, she was “met with a lot of resistance” from teaching assistants and professors. This only

fed her interest in looking at “what’s really happening in terms of labeling and diagnostic process and how much is built on these really ridiculous assumptions and power dynamics.”

As Laila’s comments also indicate, psychiatric diagnoses are heavily gendered, sexualized, and racialized, as discussed in detail in chapter one. As Metzl (2009) argues, interactions between doctors and patients are in part predetermined by institutional racism:

Race impacts medical communication because racial tensions are structured into clinical interactions long before doctors or patients enter examination rooms. To a remarkable extent, anxieties about racial difference shape diagnostic criteria, health-care policies, medical and popular attitudes about mentally ill persons, the structures of treatment facilities, and ultimately, the conversations that take place there within” (Metzl, 2009, p. xi).

While Metzl is referring specifically to race, his arguments also apply to gender and sexuality. Like Laila, many of the participants critiqued the diagnostic process based on their critical consciousness about power, race, gender, and sexuality.

For example, Jaime, a racialized, lesbian, trans person in Winnipeg told me that she does not trust psychiatric diagnoses because of many disciplinary experiences with systemic power throughout her life. She said that her experiences as a youth with the police and with Child and Family Services (CFS) convinced her that “any sort of person who wore a uniform or had some form of power to be able to control you or apprehend you, you know, sucks.” Agents of the state such as police and CFS often act as disciplinary forces in racialized communities and Jaime explained that she sees doctors as

yet another vector for institutional power “that will tell you what they think is right.” Her perspective was also shaped by her experiences in prison, where she was assessed by a psychiatrist and a psychologist:

It was a part of assessing my rehabilitation or whether I can be released. The psychologist was like, ‘You’re perfectly fine, and you know a lot, and you’re pretty smart.’ And the psychiatrist was like, ‘You’re gonna be a career criminal’ [both laugh]. I think that was also because the psychiatrist was working for the prosecutors. I just remember that standing out for me as like, ‘Okay, you just assigned me the rest of my life.’

The stark contradiction in these assessments demonstrated for Jaime that diagnostic processes are subjective judgments serving the interests of those in power. Though she does not overtly name racism as part of this process, as a person of colour her narrative can be read with this in mind given the ways that racism operates on a systemic level.

Some participants drew attention to the gendered character of diagnostic categorization. Allison, a Torontonians who identifies as white, queer, and genderqueer, described seeing a psychiatrist who diagnosed her with three mental disorders. She was critical of one in particular, because of her knowledge about how this diagnosis is gendered:

That makes zero sense to me. I don’t like that label because the label was something that has been used against women many times in the past.... In terms of my gender identity, sometimes I identify more female and sometimes I’m more male. But sometimes I don’t feel like I’m either. But biologically I’m female. So this diagnosis is something that a lot of women get slapped with and it kind of

made me go, ‘If I was a guy would you be saying this to me right now?’ And I’m sitting there and I’m going, ‘This is absurd.’

Allison resisted the diagnosis because her experience as genderqueer and her knowledge about the gendered nature of the diagnosis meant that it did not make sense as a way to describe her experiences. Likewise, Devon, quoted above, recognized the gendered, racialized, and classed nature of psychiatric diagnoses and therefore resisted the diagnosis he was given as a teenager:

Being white and middle-class and a young teenage girl, for sure. Of course you’re depressed. Of course you need to be on anti-depressants [laughs]. Like his [the doctor’s] attitude was just that probably most teenage girls should be on anti-depressants. So that was another factor in thinking that maybe it wasn’t the right thing, that it was kind of a blanket prescription and everybody was going to be getting it who walked into that office.

Devon’s critical consciousness about sexism and medical practice allowed him to critique the diagnostic process and resist the medicalization of his experiences of distress.

Many of the trans participants had an especially fraught relationship to diagnostic process and categorization. As previously mentioned, many had been diagnosed with gender identity disorder in addition to various other ‘mental disorders.’ Unlike most of the diagnoses in the DSM, the gendered nature of GID is blatant and explicit, making it easier to critique on these grounds. As discussed in chapter one, the veracity of GID is widely questioned within trans scholarship and communities and many do not accept the pathologization of gender non-conformance. However, receiving this diagnosis is

sometimes required for gaining access to the technologies of medical transition.¹¹

Knowledge circulates within trans communities about what narrative must be performed about our experiences, thoughts, and behaviours in order to receive the diagnosis and gain access to services. Many trans people, therefore, have a sense of GID as socially constructed and feel some level of agency about the diagnostic process in that many recognize the necessity of using the psychiatric system and the diagnosis of GID in a pragmatic way. As Sol, a white, queer, transgender person in Toronto, said, “I think it’s a bit of a crap issue, honestly [both laugh], and I bit the bullet to jump through the hoops to get the testosterone, so I didn’t really dispute their terms very much. I tried to frame my own experience in my own terms but not deviating super far from what they understand as gender identity disorder.”

While many trans participants expressed an ability to use GID strategically, going through the diagnostic process also had an impact on their understanding of themselves. For example, Mike, quoted above, discussed the complex effects on his sense of self as a result of “re-narrating” his life to fit the diagnostic criteria of GID. Before seeking the diagnosis, Mike was “pretty strongly feminist” in that he was “against gender” because he believed that “a lot of gender had to do with patriarchy.” Mike found that his feminist belief that gender is a “social system about power relations” was incompatible with the individualization characteristic of diagnostic criteria. While Mike remains critical of the biomedical model, his experiences with the diagnostic process caused shifts in his feminist beliefs:

¹¹ In Canada, the process is different in each province. Generally speaking it is only possible to gain access to surgery without a diagnosis of GID if one has the means to pay a private surgeon (and sometimes not even then, as some request evidence of having been diagnosed). This is therefore a class stratified situation, and it should also be noted that the public procedures for gaining access to surgery is generally much more invasive and time consuming. Those seeking hormones usually also require diagnosis.

Re-narrating my life, re-narrating everything that I thought was politically and socially important into just a sense of who I am as a person and how I fit in the world, was difficult because it involved accepting some dominant ideas about gender and also recognizing that some things were true, that not everybody, actually, was driven by this serious obsession and upset-ness about gender; a lot of people are just fine with it. So that was kind of hard for me, because the politicized view that I had enabled me to not actually address my own situation. So it was a combination of letting go of some of my politics, really, but also incorporating myself more into how I see the world and how I am in the world. So it was tricky.

Mike began the diagnostic process with a strong critique of GID and the biomedical model, but his experiences with diagnosis caused him to conclude that some parts of feminist ideology are also incompatible with the realities of trans experience. This had a profound impact on his politics and his sense of self.

As the participants' narratives demonstrate, there are a number of factors influencing participants' perceptions of the biomedical model of mental illness. These include the relief of finding a way to explain their experiences, connections with family and friends, exposure to alternative frameworks in university and community settings, and applying critical understandings of race, gender, and sexuality to the biomedical model of mental illness. One of the biggest factors affecting participants' impressions of the biomedical model was their experiences with mental health care providers, as will be further explicated in the next chapter.

As discussed at the beginning of this chapter, the biomedical model of mental illness is so prevalent that it was difficult for the participants to make their experiences intelligible without using the language of diagnosis, even when they did not fully agree with diagnosis as an organizing framework for their experiences. If diagnosis is an inadequate way of making sense of experiences of distress, how can these experiences be described? As Tew (2005) argues, “having ways of *making sense* that work for us is a crucial foundation for personal recovery and for enabling the recovery of others” (p. 10). In other words, in order to address mental distress, it is important to have a way of making these experiences intelligible. I turn now to a discussion of some alternatives to diagnostic categorizing.

Alternatives to diagnostic categorizing

Some theorists of social approaches to mental distress argue that it is helpful to shift from a language of ‘symptoms’ and diagnoses to that of ‘complaints’ (Bentall, 2003; Boyle, 2011; Tew, 2011). Following Bentall (2003), Tew (2011) argues that the language of ‘illness’ should be replaced by descriptions of “the specific experience that is troubling us,” such as hearing voices or persistent distressing thoughts (Tew, 2011, p. 29). Boyle (2011) explains that this kind of descriptive language should also foreground the context in which the complaints arise. She gives the following example to illustrate this point: “John is a widower with psychotic symptoms,” as opposed to, “The critical voices John hears may be part of a painful debate he is having with himself about whether he cared enough for his wife when she was dying” (p. 41).

Some participants who rejected the term ‘mentally ill’ were sometimes at a loss for language that felt comfortable and accurately described their experiences. Some found

it more helpful to name their specific struggles rather than taking on the pathologizing identity ‘mentally ill.’ As Margaret, quoted above, said,

I don’t know if it’s because of the word illness. I’d rather say that I’ve struggled with depression. And I struggled with, you know, suicidal thoughts, tendencies too. I mean I could admit that I have an illness with my other recovery programs but maybe it’s just like I said, the word ‘illness’ kinda throws me off.

Similarly, Rob, quoted above, describes himself as someone who experiences feelings of depression and who has “dealt with suicidal tendencies.” Bentall (2003) argues that using this kind of descriptive language rather than medicalized terminology dispenses with the need to create a definitive distinction between madness and sanity or to always assume that these kinds of experiences are pathological (p. 141).

Language is not the only thing that needs to shift in order to move away from psychiatric diagnosis. If mental distress is not due to an imbalance in brain chemistry, there is still the question of how to determine what factors lead to mental distress becoming problematic enough to interfere with someone’s life. Tew (2011) offers a useful set of suggestions for understanding when mental distress becomes disruptively problematic. He argues that there are generally a number of social factors present: the “disruption of personal agency – where some aspects of one’s experience seem ‘out of control,’” interference with “a person’s ability to carry on with their daily life (social dysfunction),” and becoming a “risk to self or others” (pp. 34-35). He believes that assessing these factors are of “more practical value” than psychiatric diagnoses (p. 34). Tew contends that expressions and experiences of mental distress can usefully be seen as “a way of coping with (or containing) our underlying unease; *and* a ‘cry for help’ that

may also express (often indirectly) what the unease may be about” rather than symptoms of a mental condition or disorder (p. 29). The next section will further clarify the kinds of experiences that can provide a social context for understanding mental distress.

Making sense of mental distress: Resisting individualization and acknowledging social context

Many participants drew attention to the ways in which their life experiences played a role in their mental distress, placing importance on the role of social contexts and adverse life experiences. This is in direct contradistinction to the biomedical model, which individualizes distress, attributing the cause to biologically-based pathologies such as chemical imbalances in the brain, rather than taking into account the social conditions and life experiences that may lead to distress and non-normative behaviours that get categorized as ‘mental illness.’ As Rapley, Moncrieff, and Dillon (2011) contend, ignoring the social context means that “more or less understandable reactions to life’s challenges” get turned “into internal individual pathology – whether labeled as depression, psychosis or some other diagnosis” (p. 4). It also means that structural oppression is minimized or ignored. As Ballou and Brown (2002) argue, the individualization characteristic of the biomedical model both silences those deemed mad and fails to take in to account “forces, dynamics, and structures” that may lead to experiences of madness. As they state, “While individual problems are certainly significant, it is also significant and meaningful that individuals are enormously impacted by multiple forces and systems” (p. xviii).

This is particularly relevant to LGBTQ people, because of the impact of homophobia, transphobia, and other forms of oppression. As Betty, quoted above, said,

I think being who I am and having queer people in my life and being queer myself and sort of living apart from a larger segment of the population, I see people get shit on all the fucking damn time because we're queer or because we're poor or different. The world doesn't always change for us or is not set up for the people that I care about.... The queer identity that I have and that the people that I care about have, that prevents them from being able to get what they need from systems that are supposed to support them, informs how I feel crazy sometimes. It's also helplessness a little bit, too. That feeling of helplessness impacts the way that I feel crazy. You know, like that crazy feeling of not being able to do anything, being completely unable to move anything or switch something so it works for people, that gives me anxiety. I think it *should* give me anxiety. I actually think it should give *everybody else* anxiety, to be honest. Like I don't think I should have to have all that. Some fucker should carry that shit for me. Whatever. That's the way it is.

Betty directly links her feelings of 'craziness' and anxiety to being queer in a homophobic and otherwise oppressive society. From a biomedical perspective, Betty's experiences of distress and anxiety would be perceived as symptoms of illness characteristic of a disordered mind. Her explanation of her experiences challenges this perspective; her anxiety response makes sense within the social context she provides. As Boyle (2011) argues, the biomedical model renders experiences of madness unintelligible through sidelining the social context in which these experiences arise. This supposed lack of intelligibility of behaviours and thoughts deemed mad is often what justifies the use of the biomedical model "or any model based on individual deficits" (p. 40). She contends

that it is therefore crucial to insist on the intelligibility of mental distress and behaviours and thoughts that seem “‘abnormal’” through focusing on “the idea that people’s feelings and actions are consonant with their past and present experiences” and recognizing that “some ‘normal’ social practices, such as gender role socialization or consumerism,” can in fact be deeply injurious (p. 41).

Indeed, there are quantitative studies linking experiences of homophobic and transphobic discrimination with ‘mental health and illness.’ Chamberland and Saewyc (2011) identify LGBTQ people as a “vulnerable population” in terms of ‘mental health,’ surmising that this is connected to experiences of discrimination and social exclusion. The Trans PULSE study results indicate a connection between transphobia and depression in both trans men and trans women (Rotondi, Bauer, Scanlon, Kaay, Travers & Travers, 2011; Rotondi, Bauer, Travers, Travers, Scanlon & Kaay, 2011). Likewise, a study that measured the effects of overt forms of discrimination against lesbians and gay men found that such experiences can have a negative impact on ‘psychological wellbeing’ (Morrison, 2011, p. 87). As McIntyre, Daley, Rutherford, & Ross (2011) argue, it is reasonable to conclude that there is a “strong relationship between perceived experiences of discrimination and mental health status, not only among LGB people but also for other minority populations” (p. 174). Of course, LGB (and queer and trans) people *are* also members of other ‘minority populations’ and can experience many kinds of oppression, as the following discussion will demonstrate.

The participants’ narratives resonate with the results of these studies, in that it is clear that experiences of oppression based on gender and sexual dissidence are linked to mental distress. For example, David, a white, Jewish, gay, cisgender man in Winnipeg,

described the oppressive treatment of boys and men who transgress the norms of masculinity and the ways in which this can lead to mental distress:

I was queer from the very get go. What I liked, what I wanted was totally against the gender role that I was supposed to have. What was great about it is [that] I was bold enough and my family was either ignorant enough or lenient enough that I went and did what I wanted to do and avoided those things I wasn't interested in.... The intersection of that with what I would call mental illness is the degree of harassment I experienced all the way through my childhood and my teenage years and in my twenties from my society.... I believe that the distress that was constantly on me, the world's response to my being, is a powerful wounding element. And I think there's no way of knowing what would have happened had my orientation and identity not been responded to in the way that it was, with acts of omission of people who did not come to my rescue, or did not come to protect me, or change the situation.... I think how they intersect, then, is my identity, the world's response, and then the condition that developed in me because of that intersection.

While David values the experiences created by being able to embrace his queer gender, he identifies society's response to it as part of what led to what he calls his mental illness. Similarly, Donovan, a white, queer, gay, cisgender man in Toronto, described the impact of being expected to embody hegemonic masculinity:

This is going back to my experiences with bullying and my own insecurities with not wanting to kiss girls in elementary school or be in art club or all of those kinds of things that made it possible for youth to pick on me were ways in which I

deviated from proper pieces of masculinity. And so because I was feminized in the things that I liked..., I think I internalized a lot of that. Especially when it came to my body image. And I think body image has a lot to do with how I understand myself to be very insecure. But then how that insecurity transposes onto an anxiety disorder. So having an anxiety disorder is my own discomfort with myself. So being called fat all the time when I was younger. And now seeing myself as someone who is fat, even though I'm not a fat person, but I can't get that out of my head. Or never having a partner...until I was in my fourth year of university because I was so scared of how people would see my body, understand myself as a queer person or a gay person. And I think that has a lot to do with how I became a problem to the psychiatrist. But I also think that my own self-worth was compromised because of all that bullying and sexual assault that I experienced.

Donovan drew attention to the negative impact of being harassed as a child for not living up to the norms of hegemonic masculinity. He explains how this harassment and the effects of fatphobia, homophobia, and sexual assault are directly related to his experiences of anxiety as well as his psychiatrization.¹²

Likewise, A.P., a racialized, queer, cisgender person in Toronto described the importance of many social factors in leading to mental distress, including “homophobia and transphobia and being the target of it and being stigmatized, being able to find a job, being rejected by your family or even milder things can affect your mental health issues or cause you to have mental health issues.” Jen, a white, pansexual, cisgender woman in

¹² Fatphobia refers to the pervasive positioning of “thinner bodies as morally, medically, aesthetically, and sexually desirable, while heavy bodies are vilified” as well as the “fear and hatred” directed at “visible body fat on oneself or others” (Saguy & Ward, 2011).

Toronto, told me that she was “concerned that regular behaviours are seen in a pathological sense” and the reason for her distress “is because of social factors and situational factors.” She went on to say: “I don’t think it’s something that’s wrong with my brain. I think it’s something that’s wrong with the context in which I grew up.” Referring to “the potential trauma that comes with hiding your sexuality in a repressive, potentially conservative environment in which you grow up,” she says, “That can have an effect on your mental health and your well-being.”

In addition to experiencing discrimination, queer and trans people often experience isolation and struggle with finding sources of social support, which can affect mental wellbeing (Gapka & Raj, 2003, Mcfarlane, 1998, Rotondi et al, 2011). The distress caused by feelings of isolation, especially at a young age, was a common theme in participant narratives. Barry, quoted above, described feeling depressed and isolated growing up “in a community where there was one gay kid in our entire school” and feeling “all alone” with no one to talk to while “starting to figure out who I was.” Aaron, quoted above, also described feeling isolated as a teenager:

Around puberty I felt like I didn’t have very many people to talk to. There weren’t very many resources in [the country where I lived], so when I tried to look up mental health online, I had a lot of symptoms that corresponded with bipolar disorder. In retrospect it was probably just puberty but I don’t know.... There was a lot of pressure in terms of still being closeted and being in a very fundamentalist Muslim country. And really my own understanding of that place was fairly limited because I wasn’t someone that was enmeshed in that community; I was an

immigrant even there. So it felt really isolating. And so that led me to think that I was depressed.

Aaron described the impact of isolation in the context of diaspora and homophobia, a deeply stressful situation that led to confusion and distress.

Some participants also discussed feeling isolated on the basis of race. Marcus, a racialized, queer, trans man in Toronto, discussed the impact of racism and isolation as a racialized person growing up in a small town:

I think growing up in [a small town] and not being surrounded by other people of colour, I think that affected my mental health in that I didn't understand what racism really was and so I thought it was just me – that people hated me. It was apparent because you're a 'chink' or whatever. I didn't know how to deal with it because there were no classes on it and nothing that reflected my culture in school. And it was also very religious – a Catholic school upbringing. It was hard for me [and my siblings] who were the only East Asians in our grade for the longest time until we hit high school and there was maybe three more.

Marcus described the impact of growing up as a person of colour in a racist society where racism is never named and assimilation is covertly enforced through Eurocentric curricula. His story draws attention to the kinds of practices that are commonly accepted as benign (white-centric curricula) that are in fact harmful and can lead to mental distress.

Trans participants often linked feelings of mental distress to not being able to transition and being forced to live as the gender they were assigned at birth. For example, Josh, an Indigenous, heterosexual, trans man in Winnipeg, described living with extreme levels of distress before gaining access to testosterone:

I went to see [the doctor] and it was like either I get the sex change or I keep doing drugs until I kill myself. Those are the only two options. I've never been that blunt with a doctor. You know I'm always quiet.... I was like either you help with my transition or I just keep on doing drugs till eventually my liver fails or something. Because I'm not a lesbian, I'm sick of living like that, I don't classify myself as a lesbian.... So he's helped me out and everything's completely changed. It's like flipping a pancake almost [laughs]. Probably about two months after starting testosterone and even my roommates, my friends noticed. As a youth I'd been in every kind of drug possible, cocaine, heroin, injecting drugs, like I amaze myself that I'm actually still alive, you know [laughs], with some of the stuff I've done.... A lot of people have noticed I'm just a lot happier. A lot happier with myself, a lot happier with life and not on a one-way road to destruction.

Josh directly links his mental distress to his social situation. He described feeling anxious and depressed for many years until he was able to begin transitioning. At that point his levels of mental distress decreased exponentially and he was able to stop taking psychiatric medications. Similarly, Rikki, a white, French-Canadian lesbian transgender woman in Winnipeg, told me that she had "life-long depression and transitioning is the cure." She described being diagnosed with depression and trying psychiatric drugs in the hopes that they would help her feel better. After four years of taking various psychiatric medications, she came to the realization that she is trans:

At that point I started getting worse because it's like I knew what I needed to do to cure myself but I was in a situation where I couldn't pursue that. So the

knowledge and not being able to do anything about it made it worse and so we tried to fight that with more medication. What happened was that I attempted suicide. When I stopped myself, clarity came to mind and I said that if I'm going to beat the depression I have to change my gender. At that point I started feeling 100% better. It was at that point I stopped taking medication.

Like Josh, Rikki experienced high levels of mental distress and attempted suicide due to the inability to transition. Once she was able to change her situation and begin transitioning, she noticed a huge lessening of mental distress and stopped taking psychiatric medications.

Other participants made mention of the impact of traumatic experiences and difficult family relations as something that could lead to mental distress. Raven, a Métis, trans, genderqueer person in Winnipeg, described experiencing difficulties connected to his mother and her partner overdosing on drugs:

I was feeling kind of suicidal and self-injured a bit. And I was going through a lot of stuff at that time. I was with my mom. She's a drug user and she O.D.'d when I was eight. And also my mom's partner that she had been with for several years O.D.'d when I was about twelve and was in a coma for a little while and came out of that with brain damage and so I was with him through that, for about a year through that process and seeing him kind of come back to life a bit. Which it's lucky he did. I think it probably brought up a lot of trauma that I had with my mom O.D.-ing.

Raven's mental distress makes sense when connected with what was going on with his family. As he put it, "I think it makes sense that I have panic and anxiety. I just have a lot

of shit, I guess.... I've had a lot of trauma in my life and I think I'm just dealing with that in my body, trying to figure that out." Similarly, Margaret, quoted above, described growing up in an "alcoholic dysfunctional family" and connected her feelings of mental distress to these experiences:

I'd rather say 'survivor' than 'mad' or 'mentally ill.' Like I said, both my parents were alcoholic and well my mom did get into twelve step recovery and she did stop drinking but I feel like she wasn't really what they say, 'working her program.' She didn't take responsibility. She would act crazy and then act like someone else had the problem.

Margaret does not see herself as 'mentally ill' because her distress makes sense to her given her family dynamics. Likewise, Jen, quoted above, identified her experiences growing up as what led to her mental distress. As she said: "I became homeless at sixteen and I was homeless for two months. I had a very tumultuous upbringing. My parents were very middle-class but they were abusive and there was all kinds of emotional abuse that was going on and sometimes physical abuse." While Raven's, Margaret's, and Jen's experiences do not directly speak to the significance of being LGBTQ, it is important to note that the existence of systemic discrimination means that even in cases where oppression is not overtly obvious, it may in fact play a role. For example, becoming homeless may be that much more difficult as a LGBTQ person because of the presence of homophobia and transphobia in homeless shelter systems.

As the participants' narratives demonstrate, the role of adverse life experiences is crucial to consider in understanding mental distress. Such experiences can lead to mental distress and social approaches indicate that de-pathologizing mental distress by locating it

within social contexts positions mental distress as an understandable response to adverse life experiences. As I have shown, this is in direct contradistinction to the biomedical model, which frames ‘the mentally ill’ as unreasonable and unintelligible based on underlying ‘disorders.’ Social approaches are particularly useful for understanding LGBTQ experiences because as members of marginalized groups, they often have to contend with homophobia, transphobia, and other forms of oppression. This pushes the queer critique beyond selective diagnoses to make the broader claim that the biomedical model as a whole is problematic and that social approaches to mental distress provide another way of making LGBTQ experiences of madness intelligible. As I will argue in the next chapter, these models have very different implications for treatment.

Chapter Three: The Biomedical Model in Practice: Lesbian, Gay, Bisexual, Queer, and Trans Encounters with Mental Health Care Practitioners

In chapter two I contend that the biomedical model of mental illness is an unhelpful way of making sense of lesbian, gay, bisexual, queer, and trans (LGBTQ) experiences of mental distress. I argue that biomedicalism individualizes mental distress, treating social contexts and structural oppression as unimportant or secondary and rendering LGBTQ experiences of madness senseless and pathological. I present social approaches to mental distress as another way of making these experiences intelligible; these approaches understand mental distress as a reaction to adverse life events and experiences of oppression.

In this chapter I examine participants' experiences with mental health care practitioners in order to look at the effects of the biomedical model in practice. I explore how the ideologies underpinning health care practices govern the relationship between practitioners and those seeking care, as well as decisions about how to address or manage mental distress. I argue that the power relations embedded in the biomedical model can make for inequitable relationships and interactions, a problem compounded by a profound lack of knowledge among practitioners about LGBTQ cultures, identities, and behaviours as well as racialized cultures and processes of racialization. Furthermore, participants' experiences indicate that despite the removal of homosexuality from the DSM and increasing resistance to the inclusion of gender identity disorder (now gender dysphoria), LGBTQ people continue to be pathologized through various means. These include discourses that position nonnormative sexual and gendered behaviour, desires, and practices as deviant; diagnostic criteria that pathologize 'promiscuous' behaviour,

and the use of mental health systems and child protective services as tools of (neo)colonial regulation.

The result is that participants struggled to create equitable relationships and interactions with practitioners, which in turn affected their access to, and decisions about, ways of addressing their distress. My analysis shows that encounters with mental health care practitioners whose approaches are informed by biomedicalism are not objective assessments of mental health; rather, they are enculturated processes rife with problematic subjective judgments and discrimination. This disrupts the notion that all those who seek mental health care receive equal treatment and that the mental health system is equipped to address the needs of LGBTQ people.

As demonstrated in chapter two, the biomedical approach to understanding ‘mental illness’ extends well beyond formal healthcare settings such as hospitals and doctors' offices into counselling relationships as well as the consciousness of the participants, their support networks, and the general public. Participants were therefore likely to encounter biomedical perspectives regardless of where they accessed services, though there were differences between types of practitioners.

Participants described interactions with psychiatrists and general practitioners as those that were most heavily informed by the biomedical model of mental illness. This is unsurprising given that these types of practitioners have medical training. Seventy-six percent (28) of participants described consulting a general practitioner about their mental health and 70 percent (26) reported having seen a psychiatrist at least once. Only 16 percent (6) of participants had seen a psychologist, making the nature of these experiences more difficult to evaluate. Eighty-four percent (31) of participants had seen a

counsellor at least once. Counsellors were less likely to be strictly informed by biomedicalism and more likely to make use of critical perspectives; for this reason these experiences are not the primary focus of this chapter. Only 5% (2) of participants had never seen a psychiatrist, psychologist, or counsellor.

Availability of services in Winnipeg and Toronto

Participants' access to services and their choices about what type of practitioner to see were shaped by provincial insurance coverage. In Manitoba and Ontario, mental health care practitioners who are covered under provincial health insurance include general practitioners and other service providers practicing in doctor's offices such as social workers, psychologists, and psychiatrists. Psychiatrists practicing in hospitals are also covered. Other publicly funded services include hospital emergency services, hospital in-patient and out-patient programs, and support groups operating within hospitals. Some community health centres receive funding to offer free counselling, support groups, crisis lines, and in some cases mobile crisis response and short-term residence. These services are often limited by catchment area, have extensive waiting lists, and are therefore difficult to access. Private practice counsellors are not covered under provincial insurance, making them accessible only to participants who could afford it and those who had insurance coverage through work. Those who were students had access to counselling through their post-secondary institutions.

As this description suggests, the most readily available provincially-covered services are those that are located in institutionalized medical settings like hospitals and doctors' offices and are most likely to be informed by the biomedical model of mental illness. This means that participants were likely to have their experiences of distress

medicalized. Furthermore, services that are not explicitly LGBTQ-focused are highly likely to be inaccessible or hostile to LGBTQ people in a number of ways, regardless of whether they are mainly informed by biomedicalism. This made it particularly challenging for participants to find adequate mental health services.

In terms of mental health care services that are LGBTQ-centered or explicitly LGBTQ-friendly, the context in which the participants sought care was different according to whether they lived in Winnipeg or Toronto. Winnipeg, the capital of Manitoba, is the largest city in the province with a population of approximately 700,000. According to the 2006 census, ten percent of Winnipeg's total population is Aboriginal, the biggest urban population of Aboriginal people in Canada (Statistics Canada, 2006). The impact of colonization is highly visible; as Silver (2004) claims, "Winnipeg is a deeply segregated and racist city. This is the legacy of a long and still-present process of the colonization of Aboriginal peoples" (para. 4). Racial segregation is reflected in Winnipeg's LGBTQ community and the health-related services that are available for LGBTQ people, as will be seen below.

In terms of health services available for LGBTQ people in Winnipeg, the Rainbow Resource Centre offers drop-in counselling and short-term counselling, peer support groups, including some that are trans-specific, group counselling, and youth programming. There is a Gay Men's Clinic for gay and bisexual men at Four Rivers Medical Clinic. This clinic offers family practice care and a clinic for gay and bisexual male youth. It also serves trans men who are gay or bisexual, though this is not explicitly stated on their website. Klinik Community Health Centre is known to be LGBTQ-friendly and offers an extensive list of health services, including family practice,

counselling, crisis lines, and HIV and STI screening. Likewise, Mount Carmel Clinic is known to be LGBTQ-friendly and offers many services to those living in the north end of Winnipeg, including family practice, counselling, and support services aimed at various groups such as immigrants and refugees, young parents, and homeless people with mental illness. One program at the clinic, Sage House, offers health and support services to street-involved women, explicitly including trans women. Nine Circles Community Health Centre is also known to be LGBTQ-friendly and provides STI and HIV testing and primary care for those living with HIV.

For trans participants in Manitoba and Ontario, mental health care is more overtly entwined with trans identity. Trans people who seek hormone therapy and surgeries must acquire the help of medical professionals. This often involves contact with mental health care practitioners and receiving a diagnosis of gender identity disorder (now gender dysphoria). The vast majority of general practitioners do not prescribe hormones or have the necessary knowledge about trans health to support trans patients. This means that trans people have to find trans-specific health services, unless they are already in the care of a general practitioner who has been educated about trans health or is open to seeking such education.

Prior to the launch of a trans health clinic at Klinik Community Health Centre in December 2009, trans people from Manitoba were sent to the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario. The trans clinic at Klinik runs two evenings a week, with a waiting list of eight months. This clinic supports trans clients in their transition and provides prescriptions for hormones and referrals to surgeons who perform trans-related surgeries, some of which is provincially covered. There is one clinical

psychologist, Jules Henderson, who is known to be trans-positive and provides the documentation that is necessary for access to hormones and surgeries. This service is covered by provincial insurance, if accessed through a referral from Klinik. As of March 2013, Mount Carmel Clinic has been working on establishing a new weekly trans health clinic.

In Winnipeg, there are no LGBT-centered services that offer mental health care services from an Indigenous cultural perspective. There are several Indigenous organizations such as Aboriginal Health and Wellness Centre, Ma Mawi Wi Chi Itata Centre, and Ka Ni Kanichihk that offer a wide range of health and wellness services based on Indigenous culture, but do not specifically include two spirited and LGBTQ people in their mandates. One participant, Travis, a Métis, queer, cisgender man, described this problem as twofold. First, “Winnipeg is very divided in terms of race, in terms of Aboriginal and non-Aboriginal.” He explained that in the north end of the city, there are services run by and for Aboriginal people, whereas in the south end, social services are white dominated in terms of who works there and controls the organizations. Second, he described not only “the divide between Aboriginal and non-Aboriginal” but also the “weird idea” that “if you’re Aboriginal and you’re queer, people don’t know what to do with that.” He explains, “They either want you to be one or the other. And then if you’re in those spaces, it’s typically one or the other.” This leaves Indigenous two-spirited and LGBTQ people without services that acknowledge their specific needs as two-spirited or LGBTQ and Indigenous individuals. There is a group called Two-Spirited People of Manitoba Inc: Aboriginal Gay, Lesbian, Bisexual and Transgender

People, that seeks to address these issues by running trainings and workshops for organizations that wish to hire them.

Toronto, the biggest city in Canada with a population of about 2.79 million and 5.5 million in the Greater Toronto Area, is often touted as a diverse and multicultural city. In terms of LGBTQ-specific services, the Sherbourne Health Centre is a community health centre that offers a number of services, including primary care and support groups for those who are homeless, newcomers to Canada, and LGBT people. The centre also offers short and long term counselling to those in its catchment area. The Sherbourne is known as the ideal place for LGBT healthcare in Toronto, but there are long waiting lists for primary care (up to three years) and counselling (one to two years). The Sherbourne also houses Rainbow Health Ontario (RHO), a provincial program aimed at promoting LGBT health and increasing access to health services. The RHO website has an extensive database of LGBT-friendly healthcare providers across Ontario. RHO offers LGBT cultural competency training in the form of a series of workshops for health care providers. It also runs the Trans Health Connection Project, which provides training for health care providers working with (or intending to work with) trans clients in the form of four-day modules on trans care and a weekly telephone helpline for health care professionals.

David Kelley Services, housed at Family Services Toronto, offers short term counselling to LGBTQ people and people living with HIV/AIDS. The waiting list is generally at least one year long, though it was temporarily full and no longer taking names when I called to inquire about wait times in January 2013. The 519 Church Street Community Centre provides short term counselling (6 sessions only) and referrals to

other LGBTQ-friendly services. It also has health and wellness- related programs for LGBTQ people, including some that are trans-specific. Planned Parenthood offers short-term counselling for youth under 30, with a focus on underserved groups such as LGBTQ, homeless, and newcomer youth. Their waiting list is approximately one year long. The Griffin Centre offers mental health programs for LGBT youth and adults, including those that address depression, discrimination, sexuality, substance use, and more. The Lesbian Gay Bi Trans Youth Line is a distress line that provides peer support to youth under 26 years of age in Ontario. The Hassle Free Clinic is known to be LGBT-friendly and specifically includes trans people in their gendered hours of operation (they have separate hours for women and trans people and men and trans people). It provides STI and HIV/AIDS screening and other sexual health related services. Two-spirited People of the First Nations offers counselling and referrals, outreach, research, and curriculum development for Indigenous Torontonians.

Trans people seeking surgeries covered by Ontario provincial insurance must undergo psychological assessment and be approved for surgery at CAMH. There is a waiting list of at least one year to be seen and the approval process can take one to three years. CAMH has a fraught history with trans people and is heavily critiqued within trans communities, but it is the only option for trans Ontarians seeking provincially covered surgeries. Those who have the means can pay for surgeries privately, though often they require at least one letter from a mental health professional indicating readiness for surgery. The Sherbourne Health Centre and some endocrinologists and general practitioners who have completed training through RHO are willing to prescribe hormones, usually after an assessment of readiness.

Access to LGBTQ-specific health care in Toronto is by no means ideal, but there are more options than there are in Winnipeg. For example, the RHO database of LGBT-friendly health care practitioners, programs, and services across Ontario had a total of 229 entries when I accessed it in April 2013. The Rainbow Resource Centre in Winnipeg purportedly has a list of LGBT-friendly practitioners, but was unable to locate it when I called to inquire in April 2013. I also asked the Trans Health Clinic housed at Klinik if it has a list of trans-friendly providers and was told that they would love to, but have no one to put on such a list. As well-resourced as Toronto is, however, participants located in Toronto identified the same difficulties with service provision as those located in Winnipeg, with only a few context-specific differences. For this reason, I discuss participant experiences as one large group throughout the chapter, mentioning context-specific differences where relevant.

Power dynamics in relationships informed by biomedicalism

The nature of the relationship between the practitioner and the person experiencing mental distress is crucial, whether the relationship is new or ongoing. Many participants emphasized the importance of trust, collaboration, respect, and ally-ship and indicated that interactions with these characteristics were exceedingly difficult to find in the mental health care system. Indeed, the biomedical model of mental illness can make for inequitable relationships between practitioner and patient. As discussed in chapter two, the biomedical model positions those experiencing mental distress as deficient and in need of correction, as irrational and incapable of making informed decisions, and as fundamentally different from those who are considered sane. These problems are compounded by homophobia, transphobia, racism, and other forms of oppression. While

not all individual practitioners explicitly embrace these beliefs, they are implicit in the ideology governing medical practice and informed the way many practitioners interacted with the participants.

A major theme that emerged from the participants' stories about their encounters with practitioners was the unhealthy power relations that governed these interactions and relationships. Many participants indicated that there is an inherent power imbalance in a model that sets up practitioners as all-knowing experts with the power to assess and diagnose those experiencing distress. As one participant, Raven, a Métis, trans, genderqueer person in Winnipeg, said: "I'm generally somebody who can fucking say what I mean and stand up and advocate for myself. But when it comes to doctors and people in health care, there's just such a fucking power dynamic, like power imbalance. There's just nothing you can do." Participants described interactions that felt cold and distant, with no collaboration and often no respect. Many felt as if practitioners had limited or no regard for their agency. For example, Donovan, a white, queer, gay, cisgender man in Toronto, described feeling frustrated that his psychiatrist was unwilling to share information with him:

I met resistance in that counselling work where I really had to ask, 'Can I look at my notes?' 'No.' 'Well why? I want to know what you're saying about me. I see you frantically writing, I want to know what you're writing. Are you writing, 'He's really crazy?' Are you writing, 'I'm bored?' Are you drawing a happy face? Like what are you doing?' But they won't share that with you.

Donovan's attempts to equalize the relationship through information sharing were shut down, reducing his trust in his psychiatrist. This lack of transparency was common, with some participants experiencing outright deception from practitioners. Andrea, a white, queer, cisgender woman in Winnipeg, described being "tricked into using a psychiatrist" by her general practitioner after telling him that she believed she has fibromyalgia:

He said he was sending me to a specialist. When I arrived there he started asking me all these questions about my childhood and all that kind of thing and I was like, "Why are you asking me these kind of questions? Are you a rheumatologist or something?" He's like, "No, I'm a psychiatrist.

Didn't your doctor tell you that?" And I was like, "Ahh, no."

Andrea needed forms completed by a doctor that would validate her inability to work in order to receive disability benefits from Manitoba's Employment and Income Assistance program. She believed the psychiatrist had completed these forms based on a diagnosis of fibromyalgia:

He said he would sign my medical forms..., but instead of putting fibromyalgia he put borderline [borderline personality disorder] and somatic personality [somatization disorder]. And he hadn't even shared that diagnosis with me. It was shared to me by Employment and Income Assistance.

Andrea was deceived by both her general practitioner and a psychiatrist, who gave her a diagnosis that indicated that he did not believe in the veracity of the fibromyalgia

diagnosis and her account of her symptoms.¹³ Andrea believes that part of the reason her general practitioner sent her to the psychiatrist was that he saw her as an “insane queer woman.” She believed she was seen as less credible because her doctor espoused homophobic beliefs and positioned her sexuality as a form of mental illness. As she put it, “Just like, ‘You’re crazy. Gay.’”

The lack of transparency about diagnosis may be of particular concern for trans people. Devon, a white, queer, trans man in Toronto, indicated that he was kept in the dark about being given a diagnosis of gender identity disorder, discovering this years later through a third party:

I didn’t see the diagnosis until eventually I had a endocrinologist who asked me a lot of psychological questions, which I thought was really weird because she was asking me more personal questions than the shrink actually did. But she eventually gave me all of my health documents when I moved...so I could give it to whatever doctor I’d go in to see. In that I saw some of the original documents and saw that "this patient has been diagnosed with gender identity disorder" on it and realized that I had been subjected to some designations and some pretty specific terms that I didn’t realize had been applied to me.

While Devon was initially surprised, he said: “I guess the assumption is that you know that that’s why you’re there, so you want to get that designation [both laugh]. I think they would be a little, ‘What did you expect? [laughs].’” However, Devon was not alone in his unawareness. Other trans participants indicated that they didn’t know a diagnosis of

¹³ Somatization Disorder is diagnosed when there is no physical medical condition causing the reported symptoms or the reported discomfort exceeds the expectations of the practitioner based on evidence such as physical examination (DSM-IV).

gender identity disorder was required in order to access publicly funded medical technologies of transition. For example, Brayden, a racialized, gay, trans man, told me, “I don’t think that’s how it works out here,” despite having already seen the doctor at the trans clinic in Winnipeg. This indicates that there is potentially a lack of clarity and transparency about sharing diagnoses. Though there is a culture of informal knowledge exchange in trans communities, practitioners should not assume that all trans people already know they will be officially diagnosed before being allowed access to medical transition. The importance of this should not be underestimated. Many trans people disagree strongly with the pathologization of trans identities and behaviours and some go to great lengths to avoid having their transition psychiatrized.

Many participants also described condescending and paternalistic practitioners. For example, Margaret, a white, bisexual, queer, cisgender woman, told me the following about her experience in a hospital in Toronto:

The questions were just too stupid and we were sitting there for a while and I kind of got annoyed. Like they started asking me, “What day is this?” “What floor are we on?” and “Where are we?” And by that time I felt like saying something smart-ass like “Mars” and, you know, “The forty-first of October.” Like shut up. What do you think I’m going to say, right?

It sounds like Margaret was assessed using a standard tool of psychiatric assessment, the Mental Status Examination. The section she described above is aimed at assessing level of cognition but was experienced as insulting and paternalistic. As Margaret’s comments

suggest, the application of standard assessment may sometimes be at the expense of being attuned and helpful to someone experiencing distress.

Likewise, Viki, a racialized, queer, gender-fluid woman, felt that psychiatrists were not attuned or caring and were instead “formal, not supportive,” as well as “offensive, judgmental” and “not really caring about the person.” She attributed this to the medical model:

I think because there’s such a medical model with so many psychs that when you’re talking about someone’s emotional and mental well-being, I feel like you should pay attention to the emotions they’re talking about and the mental state that they’re in. A lot of the times that doesn’t happen.

I’ve had doctors pass comments about the way I look. I recently had a psych tell me that I was defiant. I find it really offensive that the supposed objective is someone’s mental health, but there are insensitive, rude things that are passed that don’t even consider where they’re at or who they are.

Things like my gender and my sexual orientation can often be targeted.

As Viki’s story also indicates, the power imbalance between practitioners and those experiencing mental distress is compounded by oppressive beliefs and lack of knowledge about LGBTQ cultures, experiences, and identities.

“Going back to gender and sexuality 101”: Practitioner ignorance

Participants often came into contact with mental health care practitioners who had little to no knowledge of LGBTQ cultures, identities, and experiences. While this problem is not limited to approaches informed by the biomedical model, medical training generally does little to acknowledge or address this problem (McIntyre, Daley,

Rutherford & Ross, 2011; Rutherford, McIntyre, Daley, & Ross, 2012). A recent survey of 150 medical schools across Canada and the United States shows that the median amount of time spent on LGBT issues in the curriculum is five hours (Obedin-Maliver et al, 2011, p. 971). Due to its large, diverse population, Toronto may be assumed to be a well-resourced city for LGBTQ people. However, participants in both Toronto and Winnipeg indicated that unless they were receiving services at an LGBTQ organization, they encountered practitioners who demonstrated a profound lack of knowledge. This serves as a major barrier to providing adequate care to LGBTQ people.

For example, Jen, a white, pansexual, cisgender woman, described seeing a psychologist in Toronto who could not understand her partnership with a trans woman: "I was like, 'We've spent half these sessions just trying to clarify stuff about transsexuality to you. That's not my job. It's not my job to teach you. You're supposed to be the professional.'" Jen experienced the same problem with a psychotherapist in Toronto:

She didn't seem to know anything about queer issues or trans issues and any time I talked to her about that stuff it just seemed kind of foreign to her. I don't expect everybody to know everything, but I do expect a degree of something, you know [both laugh]. So that was difficult. I don't want to have to feel like I have to explain the basics, like going back to Gender and Sexuality 101 to set up enough context for my life to make sense to a service provider.

Like Jen, many participants felt like they had to educate service providers about sexuality and gender, making it difficult to focus on the distress they came to address and

in some cases making it worse. Margaret, who was assessed at a psychiatric hospital in Toronto, encountered stereotypical thinking about bisexuality:

When I tried to be honest and open, telling them that I was bisexual, then of course they're like, "Well which do you like better?" And I'm just like, making a puking face [both laugh]. You know, "Shut up, who cares, what's it matter, why do I have to choose?" I mean I hate it when people ask me that anyway, but I just felt that was especially insensitive for people in the mental health field.

Margaret was frustrated with the obvious lack of knowledge about bisexuality and the stereotypes expressed by her practitioners, further reducing her trust in the care provided.

Practitioners who were trans-positive and trans-knowledgeable were particularly hard to come by. Mike, a white, omnisexual trans man, indicated that this is especially difficult to find after transition in Toronto:

After transition, almost impossible to get anybody who has any kind of understanding of trans issues that are not transition related or that are not gender dysphoria related. So that part I found really hard, because any kind of counselling or any services that I get now, people literally cannot wrap their mind around my history with gender.

For many participants, like Mike, this meant that they limited access to health care services. As he went on to say: "I basically can't get services anymore. And that's true for health care, too. In general I'm so far off the map of what's regular that doctors and clinicians are not trained to deal with it.... I'm articulate enough that I can say things but they still don't get it."

Though many practitioners had no LGBTQ-specific knowledge, many still behaved like ‘experts’ in this regard. Caleb, a white, bisexual, trans male Torontonion, described being seen by a general practitioner:

I get in to the room with the doctor...and he says, "Look, is it possible that you think you're trans but really you're actually bisexual?" And I was like, "Well, I think I've already considered that possibility, and I think that those things don't have anything to do with each other. So no, I think I'm trans *and* bisexual, actually. Uh, you're a jackass." I think that is a really good example of those doctors truly having no fucking clue whatsoever about queer people in general and trans people specifically.

Practitioners like the one seen by Caleb continued to act as if they knew best, despite their glaring lack of awareness. Unsurprisingly, Caleb did not feel as if he could get his health care needs met by this practitioner.

Participants in Winnipeg also reported a widespread lack of knowledge amongst mental health care practitioners. Rikki told me she felt like she wasted time seeing a psychiatrist in Winnipeg who was “a hack” and did not have the knowledge necessary to help her: “I think my psychiatrist has never been trained in GLBT, so I think she didn’t have the knowledge and so she was just trying to do whatever she could to make you feel better. But I don’t think she knew what she could do to get me through this.” Another Winnipegger, Lisa, had the veracity of her lesbian identity questioned by her psychiatrist:

I’ve talked to her about having sex with guys. And she’s like "Are you sure you’re a lesbian?".... Nobody had ever questioned that. I was mid-twenties at that point. I think to question that after I’d been out for how

many years, it was like, "Yeah I'm a lesbian. I very much don't like sex with guys, although I do it."

Lisa's psychiatrist had a rigid understanding of sexual identity categories and was unable to understand that the links between sexual behaviours and identity categories are not always straightforward. This became a sticking point in their sessions and Lisa believed that the psychiatrist continued to see her as someone who was confused and undecided about her sexuality, even though this did not reflect Lisa's sense of self.

Encountering practitioners with such ignorance of LGBTQ identities, practices, and cultures when participants were in a vulnerable position was difficult for many. LGBTQ-specific services have long waiting lists in both Toronto and Winnipeg, making it hard to use these services as an alternative. The result for some, like Derek, a racialized, queer, genderqueer person in Toronto, was to avoid health care services if at all possible: "Within the past few years, as a very queer unusual person, I've just barred, kept to like the walk-in clinics or just deal with it myself, or [my] grandma." As this discussion demonstrates, lack of knowledge about LGBTQ identities, experiences, and cultures was a significant barrier to quality mental health services.

Practitioner lack of awareness about processes of racialization and racism

Many racialized participants also reported experiencing racism from practitioners, as well as a lack of awareness about racialized cultures. For example, many mental health care practitioners are uninformed about how Indigenous cultural understandings of mental health differ from mainstream perspectives as well as about "culturally appropriate methods of assessment and counselling with Indigenous youth and adults" (Stewart, 2008, p. 49). As Travis told me about Winnipeg, there is a lack of

access to holistic practice. In his case, he saw a social worker who discussed “holistic stuff” because she had some work experience in Indigenous communities, but was not very knowledgeable. Travis found that the onus was on him to bring this perspective to the sessions. Furthermore, he states that the community in Winnipeg is small, bringing up confidentiality issues: “If you want to do spirituality stuff, the Aboriginal community is very small, right, so if you’re gonna go, who’s going to be talking to who?” Travis also encountered misinformed practitioners, like one who assumed that all Indigenous people have their medications paid for and refused to provide him with samples on this basis, making him feel “really uncomfortable with her.”

Racialized participants also experienced heterosexism from practitioners who assumed they were heterosexual, indicating a complex interplay of race-based assumptions and heterosexism. For example, Aaron, a racialized, gay, cisgender man, told me the following about his encounter with a doctor in Toronto:

The doctor asked, “So you have sex with women, right?” and marked off on the paper that I have sex with women and literally asked me three times. He’s like, “You have sex with women, right?” I was like “No.” And he’s like, “No, I mean, do you have sex with women?” And I said, “No.” And then it almost sunk in at that point and he was gonna’ etch out his mark but before he did that he thought it would be best to say, “No I mean, are you gay?” [both laugh]. I was like, “Yeah.” And finally he changed it. For me, that was not so much just homophobic as much as racist or classist. It’s not like I had on my Lady Gaga t-shirt or something. I was wearing what I consider regular clothes, jeans or whatever.

Aaron draws attention to the ways in which heterosexism intertwines with racism and classism to create wealth and whiteness as an integral part of being gay and male in the social imaginary. As a black, low income, immigrant man he is not read as gay without overtly signifying queerness through white North American norms (i.e. a Lady Gaga t-shirt) and has to actively work against disbelief that he is gay.

Many racialized participants also indicated that it was difficult to find service providers who could understand the ways in which race and racism informed their experiences. As Marcus, a racialized, queer, trans man in Toronto, said, there is a “lack of awareness” about race and racism amongst mental health counsellors, including those located in LGBTQ organizations. Marcus saw a counsellor at the 519 Church Street Community Centre who “didn’t really talk about race that much,” though Marcus would have liked to. As he put it, “It helps to have that sort of knowledge or people talking about race and understanding like race in general and intersectionalities.” When Marcus joined an LGBTQ support group about mental distress, he found that when he discussed his experiences of racism, others tried to neutralize the experience as simply bullying. When Marcus challenged this, he was made to feel as if he had to “prove that it actually happened.”

Likewise, Jaime, a racialized, lesbian, trans person, saw a counsellor at an LGBTQ-friendly organization in Winnipeg who was unable to relate to her experiences as a genderqueer person of colour. Following her unsuccessful experience there, Jaime never sought out services again. In fact, when Jaime experienced what she called “a mental breakdown” with “suicidal ideation” in which a mobile crisis unit and the police

were involved, she had no support from counsellors. Her cumulative experiences with the mental health care system made her “skeptical and fearful of the whole institution of health care” and she said that she would never be able to “get the services I need.” As these stories indicate, even LGBTQ organizations may not be well equipped to address the needs of racialized LGBTQ people, an issue that is further explored in the next chapter.

Individualizing distress through pathologizing sexualities

Participants also discussed their experiences with practitioners who pathologized their sexualities. Despite the removal of homosexuality from the DSM and increasing resistance to the inclusion of gender identity disorder (now gender dysphoria), practitioners often individualized distress by positioning participants’ sexualities and genders as the cause of their mental distress, rather than recognizing that living in the context of discrimination can lead to distress. In some cases this was blatant. For example, Sonja, a Métis, bi-queer, cisgender woman, described being assessed by a Winnipeg Health Sciences Centre psychiatry resident who “pathologized queerness and made it into this cause of disease kind of thing.” During the assessment, she did not feel safe enough to disclose her sexuality. However, once he had completed the assessment she decided to come out to him. The following ensued:

He got really upset. Not over the fact that I hadn’t told him everything, but just about what it meant to be queer and what I could expect to happen in my mental health if I continued to be queer. And I was like, “Why isn’t anybody...?” I literally looked at the mirror because there was a mirrored window or whatever, and I was like, “Why isn’t anybody coming in here

and removing this guy?" [both laugh] "I'm sorry I didn't come out, but [laughs], you know, I don't need to hear this." And no one came. And he just kinda' wrapped it up and sputtered and was like, "K thanks, bye."

In Sonja's case, the pathologization of her sexuality was direct and blatant. Other participants described more nuanced scenarios in which they felt like their sexuality was pathologized. Discussing health care practitioners and their perspectives on sexuality, Andrea, quoted above, observed, "Some of them just don't have a clue. They think that it's part of your mental health problem instead of just who you are." Andrea experienced this firsthand with a psychiatrist in Winnipeg, who she said pathologized her relationships with women and seemed more eager to diagnose her after she disclosed her sexuality.

Likewise, Lisa, whose psychiatrist in Winnipeg questioned her sexuality, also questioned her appearance. Lisa was asked, "What are you trying to say?" in regards to her blue Mohawk hairstyle, her piercings, and her tattoos. Her psychiatrist believed that Lisa's aesthetic choices were partially at fault for her struggles, placing the blame on Lisa's queer appearance rather than on the oppressive behaviours of those who discriminated against her.

Similarly, when I asked Viki, quoted above, to elaborate on the ways in which her gender and sexuality were targeted, she told me about an appointment with a psychiatrist in Toronto. Viki, who identifies as Korean, had chosen a Korean psychiatrist in hopes of creating "some sort of bridge" between herself and her parents. She found that he pathologized her appearance and behaviour for not living up to Korean cultural norms,

which consider children “property” and a reflection of bad “parenting skills” if a child “is an embarrassment.” Viki described the ways in which the psychiatrist positioned her:

He was pointing out my physical presentation as someone who wasn’t gender conformist, as someone who was queer, as someone who had piercings and tattoos. That I was an embarrassment. Which was a little hard for me to hear. And then further talked about aspects of what success meant to my family. And I said education. And I was struggling and I was trying to say that I was successful in my own way and then he said that I was not. Basically that I was a failure because I didn’t have a full-time job, I wasn’t married, I didn’t have a home. So my entire identity to this psychiatrist was defiant.

Viki’s psychiatrist used heteronormative and classist norms of appearance and success, thus deeming her a failure. As Halberstam (2011) states, “Success in a heteronormative, capitalist society equates too easily to specific forms of reproductive maturity combined with wealth accumulation” (p. 2). As Viki points out, these norms are also racialized; she was pathologized for not living up to the expectations placed on her as a Korean woman.

As these stories show, many practitioners pathologized non-normative sexual behaviours, identities, and experiences instead of looking at the impact of oppression. As Betty, a white, cisgender, queer woman in Winnipeg, put it: “They’d be like, ‘The fact that you are on the fringe and you have this queer identity is why you are feeling crazy.’ Instead of being like, ‘The context that you live in where people are homophobic douche bags is actually the supporting factor in your mental illness.’” As the next section

illustrates, this was not the only way practitioners pathologized sexuality. Some overtly problematized participants' sexual behavior by labeling it 'promiscuous.'

Pathologizing sexuality: Diagnosing promiscuity

Diagnostic criteria for many 'mental illnesses' include promiscuity, heightened or aggressive sexual drive, and 'indiscriminate' sexual behaviour. Examples include dissociative identity disorder, borderline personality disorder, narcissistic personality disorder, antisocial personality disorder, and bipolar disorder (Diamond, 2011). These criteria are judgmental and moralistic, heavily laden with assumptions about appropriate levels of desire, numbers of sexual partners, and types of relationship within which sex should take place. Arguably, these criteria are based on heteronormative values about how much sex should be had and with whom. As Warner (1999) argues, queer culture fosters an "alternative ethical culture" that challenges sexual shame and heteronormative ways of organizing intimacy, relationships, and sexual practices (vii). As he claims, queer sex "is not required to be tidy, normal, uniform, or authorized by the government" (p. 35). However, some mental health care practitioners saw queer forms of organizing sexual relations as a sign of 'mental illness.'

Indeed, some participants reported being deemed 'promiscuous' by their mental health care practitioners. Donovan, quoted above, described his sense of the beliefs of mental health care practitioners about having many sexual encounters with multiple partners: "It's this idea of morality, that they are not taking care of themselves because they're not truly good people, and because of that they're having lots of sex. So it's this idea of you're a bad person, you don't care about yourself, so you're going to have lots of sex." In this view, engaging in sex outside the bounds of a heteronormative, monogamous

relationship is perceived as a sign of moral weakness and disrespect of self. Donovan explained how his sexual history could therefore be pathologized by mental health care practitioners. However, he had his own interpretation of his behaviour:

I've went and had lots and lots of sex with lots and lots of guys and felt pleasure and hurt that way, which is interesting. But I never physically made myself bleed because I was unhappy with who I was. So I got fucked instead. And that, to me, I've created to be normal in some interesting and weird way.

Donovan reflects a similar view to the one he attributes to practitioners in that he compares having sex with many men to self-harm. He went on to say that in the past, he did not see himself as someone who was “mentally ill” because he never tried to commit suicide, only thought about it. At the time of the interview, he was reconsidering this and reflecting on how having lots of sex could be seen as self harm:

Because I have these images and understandings of mentally ill, I didn't at that time think that having lots of sex was an attribute of someone who was mentally ill. But if I was to hurt myself I would think that would be someone who was mentally ill. But I guess now thinking of it..., it's understood that if someone has lots of sex, there's more chance to get HIV or to get an STI and therefore they need to take care of themselves and if they don't take care of themselves by not having lots of sex then therefore they have a problem.

In many ways, this view is aligned with the earlier perspective, linking high rates of sexual activity with ‘mental illness’ and an inability to care for oneself. At the same time, Donovan resists this in describing his sexual behaviour as normal, a perspective perhaps aided by critical queer norms that resist heteronormative sexual relations. Donovan

expressed some resistance to the pathologization of his sexual practices while at the same time naming cutting as ‘abnormal’ and perhaps as indicative of mental ill health, a hierarchy that he was in the midst of questioning at the time of the interview (naming it ‘interesting and weird’).

Similarly, Brock, a white, gay, cisgender man in Winnipeg, found that his general practitioner positioned his sexual behaviours as unhealthy and attributed them to his ‘mental illness’:

We’ve talked about using it [sex] as a coping mechanism of borderline [personality disorder]. An aggressive sexual drive, seeking it out, sexual relationships that aren’t necessarily healthy, be it through masturbation or through promiscuous sex. And it’s been talked about like, yes, I acknowledge that I put myself in very dangerous situations. And my doctor has known this is something that you have to deal with. But we’ve approached it very justly, even-handedly.

Unlike Donovan, Brock did not express any conflict with his practitioner’s views, stating that he needs to be “more careful” about his sexual behaviour because the “long term negative side effects can be disastrous.” Having many sexual encounters also felt unhealthy to Brock because he was often hurt by “gay men’s culture” in which many men were able to “let go quickly” and not get emotionally involved. Brock went on to say that his own inability to do the same was due to having borderline personality disorder, thereby classifying both his ‘promiscuity’ and his lack of being able to feel good about it

as indicative of mental ill health. In this way he supports the links between mental ill health and high rates of sexual activity with multiple partners.¹⁴

Service providers sometimes also conflated ‘promiscuity’ with non-monogamy, with the assumption being that those who have open relationships engage in lots of sex with multiple partners. As A.P., a racialized, queer, cisgender person in Toronto, told me:

When I say that I’m non-monogamous and then they [mental health care practitioners] go into detective mode because I think that promiscuity is supposed to be a sign of things. I’m not promiscuous at all, but non-monogamous automatically equals [trails off]. Also it’s the kind of thing where doctors assume that if you identify as such that you must be some kind of deviant. There must be something wrong with you. It’s fine if you just want to meet a nice person of the same gender and settle down and adopt kids or have a puppy or something, but if you don’t subscribe to that model, then automatically it’s like maybe it’s a sign of more mental illness [both laugh].

While A.P. does not critique the concept of ‘promiscuity,’ she challenges the assumption that those who are non-monogamous engage in a lot of sexual encounters as well as the pathologization of open relationships. She draws attention to the way that homonormative relationships have attained a certain level of respectability with some practitioners, while other practices continue to be pathologized and linked to ‘mental illness.’

Smith, a white, queer, trans man in Toronto, described the difficulties of finding a mental health care practitioner who does not pathologize BDSM and non-monogamy. As he put it: “I would want to be able to find somebody who I know isn’t going to be like,

¹⁴ This is not to say that the ways in which Donovan and Brock interpret their experiences are ‘wrong’ or ‘inaccurate.’ Rather, I am suggesting that their perspectives are, in part, aligned with their health care practitioners’ views about the links between ‘mental illness’ and ‘promiscuity.’

‘Well, all of your problems are related to the fact that you’re non-monogamous or that you’re engaged in BDSM.’ I have heard so many stories about that being the case.” For Smith, who also self-identifies as “sex-positive,” the sexually conservative values embedded in biomedical ideology were unacceptable and make it difficult for him to find an adequate service provider. As this discussion shows, queer sexual practices and queer ways of organizing sexual relations were often pathologized by mental health care practitioners and treated as part of participants’ ‘mental illness.’ As this discussion also indicates, some participants grappled with the internalization of sex shaming and the pathologization of queer sexual relations while others resisted such pathologization.

Pathologizing gender identity

The pathologizing of nonnormative gender identity was even more overt, partly because of the continuing inclusion of trans-related diagnoses in the DSM. For some, whether trans-identified or not, the inclusion of gender identity disorder (now Gender Dysphoria) in the DSM meant that trans-positivity and psychiatry are completely mutually exclusive. As Bettie, a cisgender participant from Winnipeg, said: “Who is a trans positive psychiatrist? Who the fuck is that? Who’s a trans positive psychiatrist? Does that exist in the world? Because we’re fucking still stuck with the DSM diagnosis for that, so what the hell?” Indeed, the inclusion of diagnoses that pathologize non-normative genders had a resounding impact on trans participants, both within and apart from processes of gaining access to the technologies of medical transition.

Trans participants from Winnipeg who had navigated the mental health care system for gender identity-related needs had all done so after 2009, when Manitoba stopped referring trans people to CAMH. Since setting up its own process for granting

access to medical transition, the experience has become less pathologizing for Manitobans, as it does not take place in a psychiatric institution. The gate-keeping process through Klinik is less medicalizing, and participants who had been through the process spoke positively about their experiences with the clinical psychologist who assessed their readiness for transition. Despite this, there were still concerns about having to be diagnosed in order to gain access to services. As Rikki said:

I know that it's a requirement for us to get our surgery that we need the diagnosis. That's where it's ludicrous. I can't just say I'm trans; I have to get someone else to say that I'm trans. So if I make an appointment to see a psychologist to say, "Can you write a note to say I'm trans?" "Are you?" "Yes I am." "Okay." "I just told you I was."

As Rikki indicates, the requirement to have one's trans identity validated by being given a diagnosis of GID (now GD) is still problematic, though preferable to the process at CAMH.

By contrast, Torontonians using provincially-covered services are seen in a psychiatric institution by a psychologist and a psychiatrist and asked invasive, irrelevant questions about their sexual practices and desires. None of the participants in this study had accessed care through CAMH, either because they had paid for services privately, had not used medical technology to transition, were not interested in the concept of transitioning, or had accessed services in another province prior to moving to Toronto. However, the experiences of trans people at CAMH is discussed and critiqued within trans communities and is known to be pathologizing and harmful in some cases. For

example, Derek, a racialized, queer, genderqueer person, told me that he is “afraid of them, intensely.” He went on to say:

I attend Trans Youth Toronto, I’ve heard enough horror stories through the grapevine to be like, "I don’t want to touch CAMH unless I was paid." And knowing my own ways of identifying I would fail [names a scientist at CAMH] test in a heartbeat. The idea of conforming to a gender role makes me incredibly uncomfortable and conforming to a gender performance as well.

Derek is referring to a scientist at CAMH, whose beliefs and practices concerning trans children and adolescents are contested by trans activists. The test Derek refers to is the expectation that those seeking medical transition conform to a binary sense of gender and provide ‘proof’ of having performed it over a ‘long enough’ period of time. Those who identify as genderqueer or otherwise challenge binary genders have a difficult time gaining access to medical transition through CAMH.

The “horror stories” Derek refers to can also affect the way that practitioners outside of CAMH are viewed. For example, Caleb, quoted above, told me that he “took the whole conversation of transness off the table” with his therapist because he feared he would be pathologized for being trans. This was partially due to what he knew about CAMH’s practices:

A lot of trans people, especially here in Toronto, those folks who go to CAMH, have had to deal with psychiatrists and psychologists presuming that their mental illnesses that they may have in addition to transitioning are either because of being trans or vice versa, that being trans is because of mental illness. And both of those things just cause me so much rage, for obvious reasons.

Caleb knew that the pathologizing of trans people is still rampant and wanted to avoid the possibility of hearing these views espoused by his therapist. Similarly, Devon, another Torontonians, believed that he would always be perceived as mentally ill by any mental health care practitioner, regardless of his mental state, by virtue of being trans:

I imagine that because transsexuality has a history of pathologization that I'm already seen as having that pathology. So I'm already being viewed as mentally ill right off the get go. And it may be in my case that my anti-depressants are injectable, but that's how I feel that I'm being viewed in that moment and I don't like it.

Devon is referring to his testosterone shots as anti-depressants, suggesting that while the technologies of medical transition may prevent him from being depressed ("my anti-depressants are injectable"), he should not be positioned as mentally ill for being trans.

As this discussion shows, mental health care practitioners are often viewed with suspicion and fear by many trans people, because of the ongoing pathologizing of non-normative genders, and are often far from being helpful resources for trans people experiencing mental distress.

Pathologizing Indigenous LGBTQ people

Similarly, many Indigenous LGBTQ people have reason to view mental health care practitioners with distrust. The mental healthcare system can be seen as a tool of colonization, rather than providing a way to heal from it. For example, the system often works in tandem with child protective services in displacing and controlling Indigenous people. As outlined in chapter one, Indigenous people have long been deemed 'mentally ill' and institutionalized for resisting white domination (Menzies & Palys, 2006; Kanani,

2011; Yellow Bird, 2004; Vermette, 1988). Moreover, the child protection system in Canada is governed by federal and provincial legislation that does not recognize tribal authority and fails to meet the needs of Indigenous youth, who continue to be over-represented in the system. (Baskin, 2007; Bennett, Blackstock, & De La Ronde, 2005). As de Leeuw, Greenwood, and Cameron (2010) argue, the Canadian child welfare system takes up where the residential schooling system left off, based as it is on the same “colonial discourses of Indigenous deviance and governmental trusteeship” (p. 289). They contend that the Canadian government ignores its own role in creating the social determinants of poor health conditions for Indigenous people, while continuing to reproduce narratives about Indigenous deficiency in terms of addictions and mental illness to justify violent interventions (de Leeuw, Greenwood, & Cameron, 2010).

The ill effects of these systems on Indigenous people were described by one participant, Travis, a Métis, queer, cisgender man who was employed in social services in Winnipeg. He indicated that the impact of colonization and the ongoing negative effects of the ways in which child welfare agencies interact with Indigenous families result in a no-win situation for Indigenous youth:

There’s just such a long history of colonization and the impact that has on folks.... I worked with primarily young people involved in the child welfare system. That system isn’t able to meet their needs in terms of anything actually. The kids would have access to doctors and psychologists, but I’ve heard from a lot of youths whose social workers just send them to the psychologist and they don’t like that, so there’s a big disconnect there.... It’s hard for some inner-city Aboriginal street-involved young people to be sent to a doctor to help them when

they've been bounced around the child welfare system, haven't seen their family in years, bounced from the streets to shelters to the streets and they're fifteen years old.

It is helpful to read Travis's comments alongside those of another participant, Josh, who discusses his experiences as an Indigenous trans youth in Winnipeg, to demonstrate the damage that can be inflicted by these systems:

Through Health Science Centre and it was called Manitoba Adolescent Treatment Centre. They [Child and Family Services] had put me in there because they had a shortage of group homes when I was thirteen years old. Their way of interacting with the people that didn't want to talk to a psychiatrist was by locking us in a rubber room which was the size of a bathroom. Had a camera, a hole in it, they'd leave you in there. They'd put us in these little rooms and if we don't want to talk to a counsellor about our problems, that was the ultimatum. Being put in this damn rubber room. And you know, coming from a small town and being abused by all these people and then being thrown in a psych ward and being forced to talk or we'll put you in a rubber room. 'Well I don't care, I'll sit here all night if you want, you know.' I was pig-headed; everybody knew I was pig-headed. I'd sit there for hours and hours on end.... After three months I got a new psychiatrist and he took me out of there. He's like, 'She doesn't belong in there,' and placed me in another group home finally. That was a pretty horrible experience.

Josh's experiences show how the mental health system and child protective services play a part in ongoing violence against and displacement of Indigenous people. Josh's experiences were also imbued with transphobia. After telling another psychiatrist at

Health Sciences Centre that he was a boy, Josh was told he was crazy and heavily medicated. His experiences with these systems was deeply traumatizing; Josh told me they led to “a lot of self-mutilation, like cutting and slashing my wrists and deep cutting and stuff like that.” This in turn led to further medicalization and intense racism from health care providers:

One doctor’s pissed off ‘cause one time had to put seventy-two stitches to put my arm back together and he’s pissed off. ‘I see you here every week at the Health Sciences [Centre], I see you here every week, every second day, you know what’s your problem? If you want somebody to hurt you, come here and I’ll punch you in the eye.’

Josh’s story reveals the deeply racist character of health care provision and the ways in which Indigenous bodies are seen as worthless and disposable. This is in keeping with incidents like the 2008 death of Brian Sinclair, a homeless, disabled Indigenous man who waited 34 hours in the emergency waiting room of the same Winnipeg hospital before he died from a treatable bladder infection because he was ignored and assumed by staff to be intoxicated (Puxley, 2013). The impact of colonization, oppression and marginalization in the context of a racist health care system can literally mean death.

As I have been arguing throughout this chapter, the biomedical model underpinning health care and social welfare practice can make for unhealthy or destructive power dynamics and this is compounded by lack of knowledge about and the pathologizing of non-normative genders, sexualities, and racialized people. As will be discussed next, biomedicalism also informs assumptions about the best way to treat mental distress and the relationship between practitioners and those seeking care.

Biomedical methods of managing mental distress: Medication as ‘corrective’

The biomedical model’s foundational assumption that mental illness is caused by a chemical imbalance or physical dysfunction in the brain leads to medication as the means of ‘correction.’ Most participants who came in contact with medical professionals regarding their experiences of mental distress were met with practitioners who believed in psychiatric medication as the first line of defense, often at the expense of addressing the social context of their distress. Sixty-two percent (23) of participants reported having taken psychiatric medication at some point, prescribed by a general practitioner or a psychiatrist. While some psychologists and counsellors also suggested medication as a means of treatment, they were unable to prescribe drugs and were more likely to also acknowledge and address the social contexts of participants’ experiences.

The chemical imbalance theory provides a widely held rationale for the prescription of psychiatric medication as a form of treatment. However, oppressive beliefs about marginalized groups can also play a role in practitioners’ decisions about who requires treatment and of what sort. A study of American clinicians found that they were more likely to believe that lesbians and gay men were in need of psychiatric medication based on their evaluation of fabricated case descriptions of lesbian, gay, and heterosexual patients (Biaggio, Roades, Staffelback, Cardinalli, & Duffy, 2000). The fictional patients in this study were all white, giving no indication of the role of racism in the clinicians’ evaluations. However, as Fernando (2010) argues, decisions about type of treatment are rife with subtle forms of discrimination based on race. For example, anger or depression due to the effects of racism is often not appreciated by mental health care

practitioners, who may therefore perceive racialized patients as out of control and in need of sedation or seclusion (Fernando, 2010, p.112). As he states:

If the anger is recognized as emanating from psychological or social problems, psychotherapy or ‘sociotherapy’ (ways of influencing behaviour by manipulating the environment) may be seen as the patient’s need. If the cause of a person’s depression is appreciated by the psychiatrist, psychological treatment may be used, while if it is not, ECT or antidepressant medication may be considered (Fernando, 2010, p. 112).

The many ways in which homophobia, racism, and other forms of oppression influence treatment recommendations are difficult to document. As one participant, Laila, a racialized, queer, cisgender woman in Toronto, said:

I had one doctor tell me that because I was South Asian I have low pain tolerance. That was really blatant racism. I think that mostly it’s in the way that you get treated though. The assumptions that people make about you. Or the fact that they don’t think that you need treatment or that you’re exaggerating about something. And that’s harder to pinpoint.

While the reasons for it are not clear, many participants were confronted with a relentless focus on medication as a way to manage their mental distress and practitioners who were highly unlikely to appreciate the importance (or even the existence) of oppression in their experiences of distress. In addition, inequitable relationships between participants and practitioners made it difficult to acquire the necessary support in making decisions about medication.

Psychiatrists in particular were guilty of providing medication as the only response. Participants who had seen psychiatrists frequently described brief encounters that ended with prescriptions for psychiatric medications, whether or not they were interested in taking them. The social contexts in which participants experienced distress were rarely considered important. For example, Donovan, quoted above, described his appointments with a psychiatrist in Toronto as follows:

I felt labelled. I felt constrained. I felt he [the psychiatrist] was more interested in how the medication was regulating my body and less about what I was experiencing. So “How are you sleeping?” versus, “How was you telling your parents about you coming out?” That to me is more important. I didn’t really want to be on that medication in the first place. “I’m here to talk to you and that’s why I’m here, but you don’t want to do that.” So sometimes he would end the conversations early. Sometimes I would quickly try to say, “What do you mean by that?” And he was not happy about those kinds of conversations.

Donovan found that there was a consistent power struggle with his psychiatrist and his efforts at addressing his difficulties with homophobia were rebuffed in favour of psychiatric medication as a means of treatment.

Likewise, Rikki sought the help of a psychiatrist in Winnipeg who focused solely on the prescription of medication as the answer to her feelings of depression:

Sometimes I’d be talking to him and he’d have his eyes closed like he was sleeping. Sometimes my meetings were 10 minutes long. I would go in and it’d be, “How are you feeling?” “Not better.” He’d amend the prescription and say, “We’ll try this.” I’d go back in the next week or two weeks. “How are you

feeling?” “Still not better.” “Let’s try this.” So it was just constantly throwing different types of drugs on me and it got to the point that I was really loopy. I stopped seeing him after a year.

Rikki eventually discovered that a major cause of her depression was her inability to transition, a reason not appreciated by this psychiatrist, nor resolved through medication. Furthermore, her psychiatrist’s demeanor made her feel like he was not fully present and unable to really support her.

Similarly, Raven, quoted above, was prescribed increasing amounts and types of psychiatric medications over the course of four years. Regarding his appointments with a psychiatrist in Winnipeg, he said: “That person was only there to give me medication. My appointments were maybe five, ten minutes long. He would check in, “How are you doing?,” summed it up quickly, and if there was something new going on he would prescribe something else for that and that was about it.” For every type of distress Raven experienced, he was offered another type of psychiatric medication:

It was just ridiculous. They had me on an anti-anxiety and then because I’ve never really been able to sleep properly they had me on sleeping pills and they also prescribed me Atavan which I was eating like fucking candy and then I was feeling really fucking obsessive and crazy about things so they’re like, ‘Oh, here’s some Seroquel’ and I had a fucking cocktail of stuff.

Raven eventually decided to stop taking medication because it was not addressing the social context of his distress. As he said, “I feel like if there’s not anything with that, if there’s no support, if there’s no therapy, if I’m not doing any work around it then it’s just like what are they doing? It’s just such a temporary solution.” Raven received no support

in quitting these medications from the psychiatrist who was prescribing them, indicating that there is little support available for those who want to stop taking medication.

Respect for agency in decision-making about psychiatric medication

As Raven's comments indicate, participants were not simply passive victims regarding treatment. However, their agency was often compromised in decision-making regarding psychiatric medication. Many described having contact with the mental health system when they were in crisis and feeling desperate for help. As Morrow and Weisser (2012) argue, the Canadian mental health system is "oriented towards crisis rather than prevention, leaving those to fall through the cracks who are more stable but still need help" (p. 36). This means that by the time people get to the point of experiencing a crisis, their choices are constrained, as it is more difficult to advocate for oneself or evaluate a course of treatment that is presented as the best or only option. For example, Raven, quoted above, was a teenager when he first came in contact with the psychiatric system. He described feeling "really out of control," "really paranoid," and unable to leave his house:

It had gone really fucking far, by the time I went in to talk to them. I was wanting to fucking kill myself and I was just completely at my wit's end. So I was just like, "Whatever you have to offer me, I'll do anything. Just make this go away."

And so as soon as they offered me medication I was like, "Sure let's do it."

Many participants described a similar sense of desperation. As Barb, a white, lesbian, woman in Winnipeg, said, "When you're that low down and your whole world is kind of scooped from you, you're pretty much willing to go with anything that anybody could do if they tell you it will make it better." Similarly Angela, a white, gay, cisgender woman in

Winnipeg, stated, “When you’re that sick and you end up in the hospital, you kind of just go with the flow. You’re not really open to debate and you’re not really thinking about that kind of stuff. You just go, ‘Okay, take this or okay, take that.’ My attitude was ‘I’ll try anything.’”

Additionally, the behaviour people may exhibit during a crisis is often interpreted in a sanist way; people are seen as irrational and incapable of making decisions. While it is indeed the case that support in decision-making about treatment is often needed, this kind of behavior can instead be used as justification for involuntary or forced treatment. Angela, quoted above, told me the following about her experiences in the hospital:

I didn’t want to get injected with a certain type of drug they wanted to try and they started threatening me and saying that they’re going to get a form done or something like that. They didn’t realize how sensitive I was to medications, so one of them actually made my blood pressure go down really fast.

While this kind of involuntary treatment is often characterized as for the patient’s own good, it can have long lasting negative consequences. As Tew (2011) argues, for most people on the receiving end of involuntary treatment, it can “undermine an already fragile sense of self,” create the impression that someone is dangerous, alienate them from key supports, and decrease trust in healthcare professionals (p.152-153).

Much of the biomedical approach to psychiatric medication is predicated on the assumption not only that medication is the best way to manage distress, but that medicating those in distress is for their own good. This ideology is reflected in medical concepts like ‘patient compliance,’ a term used to describe whether people take their medication as prescribed. The language of ‘compliance,’ which implies submission and

obedience, denies that people are capable of making responsible decisions about whether or not psychiatric medication works for them. Indeed, there is a field of study devoted to how to increase compliance and reduce attrition rates, with the assumption being that patients who stop taking their medication will worsen their condition (Llorca, 2008; Vlasnik, Aliotta, & DeLor, 2005). Perhaps one of the more egregious examples of this kind of thinking is the development of microchip compliance packaging, which monitors whether medication has been removed from packaging and sends a wireless report to prescribing physicians (Taylor, 2008). Another example is the development of pills containing microchips activated through interaction with stomach acid, serving the same monitoring purpose (Halley, 2010). The concept of ‘compliance’ becomes even more disturbing when connected with evidence about who is seen as ‘defiant,’ as described above.

This kind of approach to psychiatric medication ignores the fact that psychiatric medication can in some cases actually worsen mental distress. As Breggin (2008) argues, psychiatric medication can cause people to “become desperately depressed and suicidal, violently aggressive, or wildly out of control, without realizing that their medication is causing them to think, to feel, and to act in unusual and otherwise abhorrent ways” (p. 1). Indeed, the prescription of medication and the sidelining of the social context affecting the wellbeing of the participants often had adverse effects.

Some participants were prescribed medication in situations that felt unsafe. As Lisa, quoted above, said, “You go in with a [suicide] attempt, you could go home. So you have sutures with more meds. With more medicine to pop.” She described leaving the hospital on more than one occasion after attempting suicide to go home “to myself...or to

pills again or to nothing.” Similarly, Betty, quoted above, described her first experience with the mental health system as a teenager experiencing a panic attack. She went to an urgent care centre and was seen by a psychiatrist:

The psychiatrist talked to me for two minutes and prescribed me hundreds of tranquilizers. Like pretty much enough to kill, well, enough to kill myself for sure.... What did I do after that? I took a lot of tranquilizers [both laugh]. I did [laughs]. I was a teenager. He gave me a lot of drugs. What are you supposed to do? [both laugh]

Some participants described feeling much worse on medication. Mary, a racialized, queer, cisgender woman in Toronto, was prescribed two anti-depressants by her general practitioner as a young adult, immediately preceding her departure for university in another city, which was distant from her support network. She was instructed to increase her dose on her own if she felt her depression was getting worse. She said: “That’s what I did. I had to see a doctor I didn’t know on campus and she increased the dosage even more and I ended up in the hospital and they turned me away with a prescription for tranquilizers.” Mary felt like the medication was making her feel worse, but could not obtain any helpful guidance from medical practitioners. She said, “At that point I went to a naturopath because I just had no direction in terms of medication and I had to get off of it.... Obviously it [the medication] was making things worse and they just wanted to give me more.” Mary, like other participants, experienced adverse effects and did not have adequate support in making decisions about continuation, cessation, or alternatives.

In many cases, the symptoms caused by psychiatric medication were unbearable. Bettie described her struggle to find a medication that worked for her: “One of them I couldn’t even ‘get off’ when I was on it. What the hell? So that was a no-go. The other one I was super rage-y. Like anger, craziness. So that was also a no-go. Like screaming crazy, screaming on Portage [Avenue], like totally fucking out of control.” Similarly, Donovan, quoted above, described insufferable symptoms: “Taking the medication again, being on it, hating it, having sexual side effects, not being able to have sex or jerk off, being able to but not being able to enjoy it, feeling numb, feeling like a drone. I could concentrate in school, but at what cost?” For Angela, quoted above, psychiatric medication created a physical disability: “The Lithium that I was taking destroyed my thyroid. So now I have hypothyroidism forever because of that one drug. I’ve been toxic [liver toxicity from psychiatric medication] numerous times where I’ve had to go to emergency.”

Despite the undesirable symptoms created by medication, some participants eventually decided to begin taking medication again, even when they did not want to, because practitioners portrayed medication as the only alternative. Those who refuse are sometimes told they are responsible for their ill health. Donovan described feeling strong-armed into taking medication again after several years of not doing so:

Recently I actually sat in that psychiatrist’s office and said, “I don’t want to take pills, I’ve been on them, Ritalin, Paxil, I don’t want to take them.” After three or four conversations later, I was finally guilted. After [being] pushed and pushed and pushed to take pills, I gave in. I’m the type of person that is very much against medication. But I myself wanted to stop that conversation. And stop, I

guess, the feeling of being blamed or ‘this can help you’ or somehow believing that [laughs].

Though Donovan did eventually decide to stop taking medication once again, his story shows that the biomedical model is pervasive and persuasive. Even those who oppose medication and had negative experiences with it were sometimes convinced by practitioners to try again. Mary, quoted above, eventually moved back home in order to be closer to her support networks and she then chose to resume psychiatric medication. However, she felt ambivalent about this decision:

It’s a scary thing for me because I don’t really believe in it. I don’t eat anything weird, I barely drink pop, so to take something like that is difficult for me. But I’ve gotten to a point that I’m not sure when I decide that this is something that is livable and something that is an actual illness that I need to treat. It just worries me in terms of any future relationships or work. Hopefully on a minimal dose it will help me maintain a normal life.

Mary demonstrates some confusion and hesitation, seemingly somewhat invested in the biomedical model but not entirely committed to it. Her story indicates that there is a lack of support for people who want to explore options aside from medication. Likewise, Angela, who experienced serious ramifications from psychiatric medication, felt like she had no other options:

I became convinced that I need them and if I go off them I’m a high-risk. I don’t like them, I don’t want to be on them, there’s medications that I’m on right now that I want to get off of. I’m at the point where I can’t wait to see my doctor; I just want to stop. But you can’t do that, I think.... I guess they do what they do, but I

don't really trust what they're doing to me. I just want to know what I'm like off them, period. I want to know if I'm the same person.

As this discussion demonstrates, many participants did not have enough support from their practitioners to make decisions that felt right to them and were instead confronted with medication as the only way to manage distress. When medication failed to be helpful or was in fact destructive, many participants were left with no support or helpful direction from practitioners and no alternative ways of addressing their distress.

All of this is not to say that psychiatric medication is destructive for everyone. For a few participants, psychiatric medication had positive effects. Barb, quoted above, found psychiatric medication helpful because "it really takes some of the onus of life away from you." She found that this gave her time to achieve "internal healing." She believes that in some cases psychiatric medication is "for life" because "you don't go back to work for six months and have the same thing happen again." Likewise, David, a white, Jewish, gay, cisgender man in Winnipeg, found that medication was helpful for him. He told me that his brother identified as "brain damaged" from psychiatric medication and that he had "a really good reason to be afraid of medication" because pharmaceutical companies "don't give a shit" and "just need to find what they can sell." Having seen his brother's negative experiences with medication, he knew that "medications can make people sicker in the long run." Despite these views, David tried psychiatric medications and found that they had positive effects:

That was my experience, getting my life back. I can work full time... And I still work full time. Never would have been able. I can't even begin to really articulate what that was like. You go out for a walk and you could smell flowers or you can

feel the sun, you can feel the breeze and you're there. You're there. There's no static, you're not in a box, you're there.

As David indicates, psychiatric medication improved his quality of life. And because of these types of positive results, I am not arguing that psychiatric medication should be banned. Rather, I am compelled by Moncrieff, Cohen, and Mason's (2013) framework for understanding such matters (see also Moncrieff, 2008). They challenge what they call the "disease-centered approach" pertaining to psychotropic medications. This approach is the most common way of understanding psychotropic medication, which posits that they work by "correcting an underlying disease of the brain" such as a chemical imbalance (Moncrieff, Cohen, & Mason, 2013, p. 214). In contrast, they propose a "drug-centered approach," which posits that psychotropic drugs "produce altered mental states" which can be helpful and/or detrimental (p. 215). They compare this to the useful effect that alcohol has on "very shy" people in that it lowers social inhibitions, as opposed to correcting a chemical imbalance or an "alcohol deficiency in the brain" (p. 215). They call for more analyses based on the perspectives of those who use such drugs to determine the various effects they have and how they could best be used, arguing that 'users' must be accorded far more choice in the matter (p. 230).

As Boyle (2013) notes, the drug-centered approach makes room for both "positive and negative effects of psychotropic drugs" without linking them to disease and is amenable to non-medicalized perspectives regarding mental distress (p. 9). This approach makes sense in terms of what the participants shared about positive and negative effects of drugs and supports the need for increased agency regarding the exploration of various options for the management of distress. Indeed, the drug-centred approach is more

conducive to respecting choice regarding medication use. This is because it is the person taking medication who evaluates the efficacy of the drug rather than medical experts who believe that such drugs are curing an underlying disease (Moncrieff, Cohen, & Mason, 2013, p. 229).

As discussed in chapter two, experiences of oppression can lead to mental distress. This chapter shows, however, that LGBTQ people experience oppression within the very system that is supposed to aid with lessening distress. Mental health care informed by biomedicalism can make for inequitable interactions governed by unhealthy power dynamics and oppressive beliefs about sexuality, gender, and race. This means that many participants avoided the health care system when possible and struggled to find adequate care. Unequal relationships between practitioners and those seeking care, combined with biomedical assumptions about psychiatric medication as the most effective way to correct ‘mental illness,’ left participants with inadequate choices and support about how to address distress. There is a strong need for more equitable relationships between practitioners and LGBTQ people seeking care, which can only be achieved when practitioners develop a critical awareness and change their pathologizing beliefs about non-normative genders, sexualities, and racialized people. This suggests that ‘recovery’ from mental distress may be particularly difficult for LGBTQ people, who often cannot rely on the mental health system for help in this regard and who are, in many cases, ill-served by the system.

Chapter Four: Changing Directions or Staying the Course? Race, Gender, Sexuality, and Recovery in Canada's Mental Health Strategy

As demonstrated in chapter three, many LGBTQ people experience oppression and discrimination within the mental health care system and are sometimes ill served by biomedical methods of managing mental distress. This indicates that recovery may be especially challenging for LGBTQ people, who cannot always rely on the mental health system for support. The concept of mental health recovery is currently of critical significance in Canada, where ideologies about mental health and illness are arguably undergoing a paradigm shift due to the recent work of the national Mental Health Commission of Canada (MHCC), established in 2007 (White 2009, White & Pike, 2013, Morrow, 2013, Morrow & Weisser, 2012). Canada's first national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* mobilizes recovery as a key concept in 'changing directions' in the mental health system.

In this chapter I draw on *Changing Directions* as well as interview data to examine the concept of recovery for LGBTQ people who experience mental distress. I argue that there is a disjuncture between state-produced interpretations of the ways in which gender, sexuality, and race inform mental health needs and the knowledge of LGBTQ people with lived experience of mental distress and mental health service use. Most notably, despite the use of social understandings of mental health, the strategy fails to advance a strong structural analysis of homophobia, transphobia, racism and other forms of oppression in shaping experiences of mental distress, access to services, and recovery. Participant narratives indicate that there is a clear need for profound change in the mental health system in order to facilitate meaningful options for managing mental distress and recovery for LGBTQ people. However, *Changing Directions* indicates that

this need continues to be misunderstood by the state, which does not bode well for the implementation of anti-oppressive changes to the system.

What is mental health recovery?

The concept of recovery originated within the psychiatric survivor movement in the 1980s as a way of challenging biomedical prognoses of life-long ‘illness’ and reduced capacity for self-determination (Poole, 2011). Psychiatric survivors developed an understanding of recovery that is “conceptually distinct” from the biomedical view of recovery as the “remission of symptoms” (Tew et al, 2012, p. 444). In this view, recovery refers to (re)creating a meaningful life with or without experiences of mental distress and recovering from the effects of psychiatrization (Davidson & Roe, 2007; Tew et al, 2012). This could involve addressing various social factors such as “poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization” (Davidson & Roe, 2007, p. 463). Howell and Voronka (2012) argue that recovery was used by psychiatric survivors as an organizing framework for those who had been psychiatrized to “avert the medical system through alternate means (including peer knowledge and support)” (p. 2). As this discussion shows, the initial conceptualization of recovery focused on psychiatric survivor agency, addressing the social factors that can cause or exacerbate mental distress and exploring means of addressing distress outside of medical systems.

Recovery has since been taken up as a concept informing policy change and mental health service provision in the global north, most recently in Canada (White & Pike, 2013). Howell and Voronka (2012) refer to recovery as one of the “central

frameworks for organizing mental health care in the Western world” (p. 1) and Morrow and Weisser (2012) name recovery as the “cornerstone” of *Changing Directions, Changing Lives* (p. 30). However, the use of recovery in such contexts has changed its meaning and some argue that it has been reconfigured in the service of neoliberal state agendas (Harper & Speed, 2012; Howell & Voronka, 2012; Morrow, 2013; White & Pike, 2013). Howell and Voronka (2012) contend that recovery has been “incorporated into, and some would say co-opted by, medical reason and mental health policy” and is now used to “incorporate psychiatric survivors into medical systems” and reinforce “medical authority,” as mental health professionals become ‘experts’ in recovery (p. 4).

Biomedical understandings of recovery, which position mental distress as a biological deficit which can be addressed through psychiatric medications, are especially compatible with neoliberalism, which individualizes social problems and downloads responsibility from the state to the individual (Morrow, 2013). Yet even social approaches can be used in the service of neoliberalism, if ‘the social’ is narrowly defined. As Harper and Speed (2012) point out, ‘social context’ can be construed as understanding a person experiencing mental distress as part of a larger network of family and friends, thus reducing the social context to the interpersonal and ignoring structural factors (Harper & Speed, 2012, p. 15). They argue that even recovery models that acknowledge inequality do so by placing “the onus on the service user to rearticulate the effects of social inequality in terms of their individualized, responsiblized self” (p. 15). For example, ‘empowerment’ is positioned as “psychologized and individualized” rather than as a “redistribution of power” (p. 15). As they state: “these manifestations of responsible individuals speak directly to neoliberal models of the service user” (p. 16). Likewise,

Weisser, Morrow, and Jamer (2011) found in their review of the mental health recovery literature, “very few models of recovery explicitly address social and structural inequities,” whether the approach to recovery is biomedical or social (p.4). There is a critical need for such models, given the current political significance placed on the concept (Morrow & Weisser, 2012). Morrow and Weisser (2012) contend that a social justice framework would understand recovery as “both personal and social” and shaped by “social and structural barriers” (p.28). Given these various definitions, the following will examine how the MHCC positions recovery.

‘Recovery’ in *Changing directions, changing lives*

Changing Directions, Changing Lives is the work of the Mental Health Commission of Canada (MHCC), which was established by the Conservative-led federal government in 2007 with a ten year mandate to create a mental health strategy, a national anti-stigma campaign, and a knowledge exchange centre regarding mental health. The need for such a commission was established by a Standing Senate Committee that produced the 2006 report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, which listed 118 recommendations for improving mental health and addiction services, including the creation of a national mental health strategy. The first phase of the strategy creation was completed in 2009, with the release of *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*, which outlined a framework to inform the strategy. As indicated by the name of the document, the concept of recovery plays a crucial role in defining the framework and thus the strategy.

Changing Directions, Changing Lives is a 113 page document outlining six strategic directions for implementing change in the system. These are named in the executive summary as follows: (1) Promotion and prevention, (2) Recovery and rights, (3) Access to services, (4) Disparities and diversity, (5) First Nations, Inuit, and Métis, and (6) Leadership and collaboration. Each strategic direction is further broken down into four or five priorities, with recommendations for action based on each priority.

In general, *Changing Directions* reflects a departure from a strictly biomedical approach to mental health in that it includes a mixture of both biomedical and social approaches. In fact, early drafts garnered harsh criticism in the Canadian press for being too heavily grounded in social science, illustrating the dominance of the biomedical model in popular understandings of mental distress (White & Pike, 2013). A mixture of the biomedical and the social is also evident in the strategy's definition of recovery: "The concept of recovery refers to living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses" (MHCC, 2012, p. 12). This definition sounds similar to the way the psychiatric survivor movement defined recovery, in that it does not require the elimination of 'symptoms.' However, it differs in that there is no acknowledgement of the fact that people may need to recover from the effects of psychiatrization. The definition also suggests that both mental distress and the resulting 'limitations' placed on those experiencing it are caused by 'problems' and 'illnesses,' leaving no room for those who do not see mental distress as a deficit or as a social issue rather than a medical one.¹⁵ In this way, the MHCC takes the positive

¹⁵The MHCC leaves the distinction between 'problems' and 'illnesses' intentionally vague, stating that it does not "attempt to draw a firm line between 'problems' and 'illnesses,' or to resolve all of the controversies surrounding the choice of terminology" (p. 11). The use of 'problems' in addition to 'illnesses' cannot therefore be characterized as a clear departure from the medical term 'illnesses.'

sounding message of ‘hope’ while jettisoning the critical repositioning of the origins of mental distress and the resulting limitations as social and structural, thereby side-stepping state responsibility for structuring and addressing those conditions. This fundamentally neoliberal approach turns recovery into an individualized “personal journey” (Morrow & Weisser, 2012).

As others have argued, state interest in recovery is not necessarily primarily humanitarian and has much to do with economics (Poole, 2011, White, 2009). White (2009) outlines the ways in which the MHCC has positioned ‘mental illness’ as an ‘economic burden’ and potential crisis with profound economic repercussions for Canada (pp 232-234). This suggests that the motivation for pursuing recovery as defined by the MHCC is, at least in part, financial. State produced conceptualizations of recovery as being able to ‘contribute’ are telling; if one can ‘contribute’ one is not a ‘burden’ on the state or society. The initial use of ‘recovery’ by psychiatric survivors has thus been “appropriated and reconfigured” by the MHCC and “the political significance of recovery as a form of empowerment or resistance is changed” (White & Pike, 2013, p. 244), instead serving the interests of the neoliberal state.

This positioning of ‘recovery’ as an individualized process ideally resulting in the ability to ‘contribute’ puts the focus on making personal change, rather than social and structural change. The following will look more closely at sections of the strategy to examine the implications of this for how the MHCC envisions facilitating recovery for marginalized groups.

Recovery in the context of ‘diversity’ and ‘disparity’: Strategic direction four

In this section I focus on Strategic Direction Four, for which the full in-text name is: “Reduce disparities in risk factors and access to mental health services, and strengthen response to the needs of diverse communities and Northerners.” This strategic direction describes five priorities, which are named in the executive summary as: 4.1. Social determinants, 4.2 Immigrants, refugees, ethno-cultural, racialized, 4.3 Northern and remote, 4.4 Minority official language, and 4.5 Gender, sexuality. My analysis focuses on the introduction to strategic direction four as well as priorities 4.1, 4.2, and 4.5.

I concentrate on these three priorities because they include a discussion of the social determinants of mental health and the role of race, gender, and sexual orientation in shaping mental health needs. It is the only section of the document (aside from the executive summary) to make mention of the specific concerns of “lesbian, gay, bisexual, two-spirited, trans-gendered, and trans-sexual” (though notably not queer) people. As is evident even from this brief description, the strategy does acknowledge some of the social factors that influence mental distress, access to services, and recovery and is therefore not strictly biomedical in its approach. However, the strategy does not advance a strong structural analysis of the role of discrimination and oppression in shaping experiences of mental distress, access to services, and recovery and does little to acknowledge the role of the state in perpetuating or alleviating this oppression.

The introduction to strategic direction four acknowledges that there is inequality in terms of “the opportunity to achieve the best possible mental health and well-being” in Canada (MHCC, 2012, p. 57). The MHCC explains that those with “better incomes, more education, and stronger social networks” are often healthier (MHCC, 2012, p. 57). It

states that Canada recognizes these “disparities” and is committed to changing them, “where they can be changed” (MHCC, 2012, p.57). The focus of strategic direction four is on those who “are at greater risk” and who “experience disparities in access” to services, due to the following: “socio-economic status; ethno-cultural background, experience of racism and other forms of discrimination, and reasons for emigrating; living in a northern or remote community; being part of an official language (Francophone or Anglophone) minority community; and gender and sexual orientation” (MHCC, 2012, p. 57). The introduction concludes with an acknowledgment that while there is commonality within groups of people, the “intersecting dimensions” of people’s lives mean that everyone is affected differently (MHCC, 2012, p. 57).

This introduction sets the stage for the strategy’s approach to analyzing ‘disparities’ in mental health. The MHCC uses the language of the social determinants of health to explain how certain groups are both ‘at risk’ of developing ‘mental health problems and illnesses’ and have differential access to services. This seems like a clear departure from the medical model of mental illness. However, Boyle (2013) argues that the medical model has become adept at “assimilating and neutralizing” alternative frameworks (p. 14). She contends that one of the key ways in which this takes place is in making sure that social factors are always positioned as contributing factors rather than as “primary causes of mental distress and therefore primary targets of intervention” (Boyle, 2013, p. 14). Perhaps because the MHCC does not clearly set forth a strong theoretical framework, it is not entirely clear what it sees as the primary cause of distress, though as I show above, its definition of recovery suggests biomedical origins. What is clear, however, is that the ways in which social determinants are theorized is problematic. It is

already apparent from the introduction that the strategy is lacking in terms of an anti-oppressive structural analysis. With the exception of “experiences of racism and...discrimination,” the ‘risk factors’ listed focus on characteristics of the individual rather than the environment (e.g. ‘socio-economic status’ as opposed to ‘class oppression’, ‘living in a remote/Northern community’ as opposed to ‘lack of services in northern/remote communities’). The list does include racism, but this is the only place in strategic direction four where this word appears, and as will be seen, opportunities to include structural analyses of racism are ignored.

Theorizing the ‘risk factors’ as individual characteristics rather than environmental ones has consequences for perceived responsibility and intervention. If the ‘risk’ is gender or sexuality rather than transphobia, sexism, and homophobia, then there is no reason to look for external conditions that create these ‘risks’ and the state cannot be held responsible for perpetuating or alleviating these conditions. Any intervention is less likely to target structural causes and can also be framed as ‘charitable’ and ‘humanitarian’ efforts to ‘help’ marginalized groups rather than a necessary responsibility of the state. For the most part, strategic direction four stays focused on this individualistic level, though at times it does make mention of structural conditions. As will be seen, even when structural conditions are described, the MHCC does not follow through with a strong anti-oppressive structural analysis that holds the state responsible for creating, promoting, enabling, and accepting these conditions.

Priority 4.1: “Make improving mental health a goal when working to enhance overall living conditions and health outcomes”

As is the case with the introduction, Priority 4.1 draws on the language of the social determinants of health to explain the existence of disparities in mental health and

access to mental health services in Canada. The emphasis is on the role of poverty in creating these disparities and putting people at “greater risk” for “mental health problems and illnesses.” It is argued that Canada must “continue” to address poverty in order to reduce these disparities while employing a “health equity lens” to ensure that this is effective. The ‘health equity lens’, though not defined, is said to be important because policies have a differential impact on and within broad categories of people. The example given to illustrate this is that “women with lower incomes may be less likely than those with higher incomes to respond to an initiative to improve women’s mental health” (MHCC, 2012, p. 58).

The strategy places the responsibility for the inequitable result on the response of the women with lower incomes (they are “less likely to respond”), rather than on the policy itself, which may well have been designed to benefit the more privileged group, whether intentionally or not. Morrow (2013) argues that this is typical within “more medically oriented mental health literature” wherein the “language of epidemiology (‘at-risk populations’) is imported as a way of individualizing the social problems underlying the experience of distress” (p.327). As she contends, this literature often fails to recognize that “the ways in which services are designed, and the assumption that they operate under, may reproduce the very inequities they purport to ameliorate” (p.327). Unfortunately, this lack of attention to the ways in which services perpetuate inequities is evident throughout strategic direction four.

Priority 4.1 ends with three recommendations for action, the first of which is to: “encourage government leaders to spearhead collaborative action to reduce disparities in living conditions, while also improving mental health outcomes” (MHCC, 2012, p. 59).

This is an important recommendation that recognizes that social factors such as living conditions can have an effect on mental health. It is, however a bit vague, “encouraging government leaders” rather than, for example, ‘funding anti-poverty initiatives’ or ‘building more subsidized housing.’ The use of the passive voice also makes it unclear as to who will be doing the work of this ‘encouragement’ and what shape it will take.

The second recommendation is to “use ‘health equity lenses’ to ensure that new mental health policies and programs reduce disparities while improving mental health for the population as a whole.” The problems with this have been outlined above, not the least of which is that there is no definition of “health equity lenses.”

The third recommendation is as follows: “Strengthen data and research to develop a better understanding of the mental health needs and strengths of diverse population groups.” This is a positive recommendation, as there is no doubt that there is a need for more research that focuses on marginalized groups. However, the recommendations as a whole do not follow through on suggesting changes that significantly address the structural conditions of poverty outlined at the beginning of priority 4.1. This is achieved in part through the use of epidemiological conceptions of ‘at-risk’ groups that minimize structural conditions and thus state responsibility. As will be seen, this is a recurring theme throughout strategic direction four.

Priority 4.2: “Improve mental health services and supports by and for immigrants, refugees, ethno-cultural and racialized groups”

Priority 4.2 continues to use the epidemiological language of ‘at risk’ groups to describe the links between mental illness and immigrants, refugees, and ethno-cultural and racialized groups. According to the MHCC, many members of these groups have trouble finding employment, making an adequate income, and finding housing. The

examples used to illustrate this are newcomers to Canada who are “finding it increasingly difficult to obtain employment, particularly employment that matches their level of skills and education” (MHCC, 2012, p. 60). Structural racism is not named as a force shaping these conditions. As noted above, the MHCC includes “experience of racism” in the list of factors that cause disparities in mental health and access to services in the introduction to strategic direction four. However, there is no analysis of what this actually means or how it shapes living conditions that can lead to distress. The reasons for struggles in finding employment and housing are left open to speculation, rather than being explained as a result of racist state regulations, such as the ones governing foreign accreditation, which make it exceedingly difficult for highly educated newcomers to have their credentials recognized in Canada.

The MHCC goes on to discuss the barriers faced by these populations in accessing mental health services. It is explained that many do not have access to services “that feel safe and are effective because they are attuned to that group’s culture, experience and understanding” (MHCC, 2012, p. 60). The MHCC provides the reasons for this as follows: “People from diverse backgrounds can have different values and traditions that inform their approach to health. They sometimes experience and describe mental health problems and illnesses differently, which can be challenging for service providers” (MHCC, 2012, p. 57). This language implicitly identifies white, Canadian-born people as the ‘normal’ group against which others are deemed ‘diverse’ and ‘different.’ The MHCC frames the problem as the ‘different values and traditions’ that are ‘challenging’ for service providers, who in this formulation are presumptively white

and Canadian-born, rather than understanding the problem as Eurocentric and racist service provision.

Next, it is stated that services should be “modified” to be “more welcoming and effective.” The strategy names this framework as “cultural competence or cultural safety,” an approach that will allow providers to recognize “the influence that social disparities and imbalances of power can have on relationships” (MHCC, 2012, p. 60). While the recognition of power imbalances is important, the suggestion to remedy this with cultural competency is contentious. This approach has been critiqued for failing to advance an analysis of racism (Kumagai & Lypson, 2009) or of power and oppression (Pon, 2009). Similar to the approach taken elsewhere by the MHCC, the notion of cultural competency is said to use whiteness as the “standard by which cultures are differentiated” (Pon, 2009, p. 60). Pon (2009) argues that cultural competence is founded on whiteness, which operates as a system of power that confers privilege on those who are perceived as white, while marginalizing and othering racialized people¹⁶. Cultural competence also reifies and homogenizes cultural and racial categories and presents competence as a “static requirement” rather than a “critical consciousness” (Kumagai & Lypson, 2009, p. 782-783). Furthermore, in the Canadian context, cultural competency can serve as a way of suppressing and ignoring colonialism and racism by pandering to the idea that Canada is mainly a “fair and tolerant society” (Pon, 2009, p. 66).

The MHCC presents cultural competence and cultural safety as if they are interchangeable, but in actuality these approaches are quite different. The notion of

¹⁶ Whiteness informs more than just specific practices like cultural competence. It shapes workplace environments resulting in “white-normed” environments that create barriers to advancement for racialized workers, and can make it difficult for racialized workers to challenge white-centric policies and practices (Gosine and Pon, 2011).

cultural safety was developed in New Zealand by Maori nurses as a way of addressing the ways in which neocolonialism shapes health care, oppressing the Maori people and privileging White settlers (Smye & Brown, 2002). This approach uses a postcolonial understanding of culture as a complex system of representation rather than a static set of beliefs and practices and demands that practitioners be self-reflexive and aware of their own subject positions. There has been some examination of cultural safety's applicability to Canada in addressing the neocolonial context in which Indigenous people access healthcare (Anderson, Browne, Khan & Lynam, 2003, Smye & Brown, 2002).

In contrast, for the reasons discussed above the cultural competency approach is unlikely to address inequity and the lack of critical awareness in the mental health system. Cultural safety looks more promising, but has so far been developed as an approach that applies specifically to the relationship between Indigenous people and White settlers. While this is necessary and useful, there is a need for additional approaches that address power, discrimination, and oppression as they pertain to other racialized groups.

The MHCC goes on to further promote cultural competence and cultural safety as the way to address disparities in its recommendations for action in this section. The first of five recommendations for Priority 4.2 is: "Expand use of standards for cultural competency and cultural safety, including through accreditation bodies and professional associations." While the use of the cultural safety approach may be positive, institutionalizing the cultural competence approach may make it appear as if the mental health system is making a commitment to addressing 'diversity' and disparities, which may make it more difficult to make a case for anti-oppressive, anti-racist approaches. If

cultural competence is institutionalized as the way to address inequity, it may be more challenging to raise awareness and create space for approaches that address racism and white-centric practices.

The second recommendation is as follows: “Increase access to information and mental health services, treatments and supports in diverse languages.” This is an important recommendation, as evidenced by a recent Toronto report that found that many mental health services are inaccessible to newcomers because service providers are unable to understand many newcomers’ cultures and languages (Jacobsen, Farah, & Toronto Cultural Diversity Community of Practice, 2010, p. 16).

The third recommendation is to “Better evaluate the potential of traditional knowledge, customs and practices to address mental health problems and illnesses, and improve access to those that work.” This is an important acknowledgement of the necessity of expanding beyond the bounds of Western approaches. There is the potential for the implementation of this recommendation to improve mental health services. It does, however, raise questions regarding what standards of evaluation will be used and how effectiveness will be determined. If biomedical standards are used, they are unlikely to find value in non-biomedical approaches, which can be incompatible with positivist methods of measurement and evaluation.

Recommendation four is to “support immigrant, refugee, ethno-cultural and racialized community organizations in assessing local mental health needs and strengths and in taking action on local priorities, in collaboration with mental health and other service systems.” Recommendation five is to “develop and implement mental health plans in all jurisdictions to address the mental health needs of immigrants, refugees,

ethno-cultural and racialized groups, with their full involvement.” These recommendations are to be commended for emphasizing that the communities in question should be fully involved in implementing these suggestions. However, there is danger in medicalizing, pathologizing, and individualizing the experiences of immigrants, refugees, and racialized people. As discussed in chapter one, there is a long history of psychiatrizing racialized people as a tool of social control. In the contemporary context, for example, being diagnosed with ‘mental illness’ can put applications for status in Canada at risk, as the government can reject applicants who are thought to “pose excessive demands on health or social services” (Kanani, 2012). In addition, developing a “mental health plan” and increasing the reach of mental health systems in racialized communities runs the risk of further imposing the medical model of mental illness on racialized people. While the recommendations are not worded in such a way that necessarily means that this will be the case, they are vague enough to leave the door open to this possibility and there are sections of the report that suggest that this could occur. Moreover, increasing access without addressing racism and oppression within the system is not helpful, as oppressive services may in some case be more damaging than useful.

The recommendations in this section make no mention of ways to address the social conditions related to employment, poverty, and housing discussed in Priority 4.2, focusing instead on making the mental health system more accessible through increasing access to information, assessing mental health needs, and creating mental health plans. There is no discussion of the multiple ways in which the state creates conditions that lead to distress through, for example, immigration policies that mean that many have precarious status in Canada and work in exploitative labour conditions. Cultural

competence is offered as one of the ways to address ‘power imbalances,’ which ignores the structural context and neutralizing the oppression that takes place within the mental health system. In sum, the recommendations do not address the racism within the system, nor do they address the state’s role in the social conditions that may lead many “immigrants, refugees, ethno-cultural and racialized groups” to experience distress. As is also evident from this discussion, race is discussed in isolation from gender and sexuality, despite the MHCC’s nod to intersectionality in the introduction to strategic direction four. As is discussed below, Priority 4.5, which focuses first on gender and then on sexuality, similarly fails to adopt an intersectional approach.

Priority 4.5: “Address the specific mental health needs related to gender and sexual orientation”

Priority 4.5 lists several ways in which gender makes a difference in “mental health problems and illnesses.” These include the following:

Women are more likely than men to experience anxiety and depression, including depression following the birth of a child. Men are more likely to develop schizophrenia at a younger age. Girls and women attempt suicide at higher rates, but men and boys...die by suicide more often (MHCC, 2012, p. 68).

It is clear from this quotation that the MHCC espouses a binary, cisnormative understanding of gender, referencing studies using cisgender participants only and making no mention of trans and intersex people in its discussion of gender. This is further evidenced by cissexist assumptions such as the one that only women give birth to children. Furthermore, the MHCC reinforces a biomedical view of mental distress by presenting these differential rates of various ‘illnesses’ as medical facts. For example, the document states that women are more likely to experience anxiety and depression, rather

than stating that women are more likely than men to be *diagnosed* with depression and anxiety and have their experiences medicalized. Moreover, the role of race and racism goes unexamined in the discussion concerning gender. For example, Fernando (2010) argues that there is a “racist tendency to designate black people as schizophrenic” due to the ascription of “violence, suspiciousness and dangerousness to black clients” (p. 110). The MHCC ignores the racialized character of this diagnosis, stating only that men ‘develop’ (as opposed to saying they are diagnosed with) schizophrenia at a younger age. Indeed, the MHCC uses ‘women’ and ‘men’ as universal categories, without acknowledging differences based on any form of social difference.

The MHCC then goes on to state that “gender makes a person vulnerable to mental health problems and illnesses” and this means that “the impact of gender needs to be considered in prevention and early intervention efforts” (MHCC, 2012, p. 68). Despite the fact that this declaration is followed by lists of “risk factors” for cisgender women and men that are clearly created by inequity, sexism, and patriarchy, it is ‘gender’ that is blamed for this ‘vulnerability,’ rather than structural inequity and expectations associated with hegemonic gender norms.

For example, the “risk factors” listed for women are: “caregiving responsibilities, higher rates of poverty,” “domestic violence and abuse,” and higher likelihood of experiencing “childhood sexual abuse.” It is positive that the MHCC acknowledges the existence of such experiences in the lives of many women. However, the expectation that women will perform the majority of caregiving, the feminization of poverty, and violence against women and girls can be seen as effects of sexism and patriarchy. Furthermore, it has been argued that poverty and violence affect racialized women in even higher

numbers, indicating the interlocking effects of racism and sexism (Jiwani, 2006). If these facts can be ignored and the blame placed on gender, the state can sidestep responsibility for addressing these conditions through, for example, funding or creating social services for low-income racialized women.

Likewise, the “risk factors” for men are listed as those that “threaten their sense of success and achievement, such as job loss,” men’s inability to recognize having an “emotional problem” and their desire to “handle it alone,” and the fact that men “do not always present signs and symptoms in ways that are easily recognized by service providers” (MHCC, 2012, p. 68). It is positive that the MHCC recognizes that men also experience mental distress. However, the MHCC presents these risk factors as facts about men, as opposed to contextualizing them as part of hegemonic masculinity. The expectation that men will be ‘breadwinners,’ non-emotional, independent, and ‘strong’ is part and parcel of the same problematic belief system that positions women as dependent, emotional, and weak (Connell, 2002; Scott-Samuel, Stanistreet & Crawshaw, 2009). By presenting this neutrally as ‘gender difference’ as opposed to the result of social processes that (re)enforce and discipline gendered behaviour, the MHCC arguably becomes part of the social processes that recreate this worldview and naturalize hegemonic gender ideals and behaviours.

This approach also individualizes the problem and thus also the potential solutions. For example, if the problem is the way men “present signs and symptoms,” one logical solution would be to educate men on recognizing the signs of ‘mental illness.’ This strategy treats men as a homogenous, monolithic group, which runs the risk of perpetuating binary, cisnormative, heterosexist (and likely white-centric) gender

expectations. It also encourages men to pathologize any evidence of distress as ‘mental illness.’ Another logical solution would be to train providers in recognizing the ways that men apparently present symptoms, thus homogenizing and essentializing men’s behaviour based on hegemonic gender ideals.¹⁷ Again, this also keeps the biomedical model intact, placing the problem on the inability to recognize symptoms of an underlying illness, rather than examining how diagnostic criterion and the way they are applied are enculturated and subjective. An alternative would be to explore how men’s experiences are less likely to be medicalized because the diagnostic criterion for many ‘mental illnesses’ have been feminized and used as tools of social control of women. Does it follow that men who are perceived as ‘feminine’ are more likely to be diagnosed as ‘mentally ill’? Another alternative would be to examine how race and racism inform gendered expectations and diagnostic processes. For example, does the racist cultural association linking black men with violence and danger inform how they are perceived and diagnosed with ‘mental illness’ (Fernando, 2010, Metzl, 2009)?

While it is encouraging to see the MHCC consider gender at all, the way in which it is considered is limited. The sum total of the strategy’s gender analysis is 217 words. The words ‘sexism’ and ‘transphobia’ are nowhere to be found; nor are a whole set of related words and concepts. While it is not essential to use these specific terms, the strategy does not in any way discuss discrimination based on gender within the mental health care system, whether against trans people, those who are perceived as non-normatively gendered, or cisgender women. The strategy is based on a normative

¹⁷ There is a difference between arguing that hegemonic masculinity affects how men are perceived by self and others in relation to ‘mental illness’ and arguing that men present signs of mental illness differently than women. One acknowledges the socially real effects of constructs such as gender, while the other presents men as a universal group with essential characteristics.

understanding of gender that does not allow for female masculinities and male femininities. It also does not consider how race, sexuality, class, disability or any other factors may inform experience. It is refreshing to see the recognition of ‘social determinants’ of mental health such as poverty and violence, rather than a rigid biomedical explanation based solely on brain chemicals and genetic factors. However, without a structural analysis of oppression both within and outside of the mental health care system, the strategy falls short of addressing the salience of gender in mental health needs and recovery.

The next 240 words address LGBT people, which the MHCC lists as “lesbian, gay, bisexual, two-spirited, trans-gendered, and trans-sexual people” (MHCC, 2012, p. 68). This use of terminology to describe trans people is problematic. The use of “two-spirited, trans-gendered, and trans-sexual” suggests that the MHCC either disregards or is unaware that the latter two terms are not generally spelled with a hyphen and the use of ‘ed’ at the end of ‘transgender’ is contested (GLAAD, 2010, p. 10). Even more problematic is the fact that this section includes trans people in name only. The section discusses ‘sexual orientation’ and there is no mention of gender identity, gender expression, transphobia, anti-trans discrimination, or any of the issues facing trans people, indicating that the MHCC conflates ‘sexual orientation’ with gender identity and gender expression, a problem that is also widespread in health care education and protocols (Bauer, et al, 2009, p. 353). Despite the use of the term ‘two-spirited,’ the MHCC makes no mention of this group either, whether in this section or in Strategic Direction 5, which is devoted to First Nations, Inuit, and Métis people. Notably, despite its increased popularity and use, the term ‘queer’ is also not included, indicating that it is

perhaps viewed as too radical or controversial and it possibly is seen as equivalent to lesbian, gay, and bisexual, which is a notion that many reject (Jagose, 1996). This approach erases a large group of people who identify as queer, rather than as lesbian, gay, or bisexual.

The MHCC then goes on to state that “stigma and discrimination on the basis of sexual orientation have an impact on the mental health of...LGBT people” (MHCC, 2012, p. 68). This is an important acknowledgement. Similar to the paragraph about gender, the risk factors affecting mental health are then listed, which are “sexual and physical assault” and “bullying for youth” (MHCC, 2012, p. 68). According to the MHCC, these risks can be mitigated by “accepting family” and “connection with other LGBT youth” (MHCC, 2012, p. 68). Furthermore, the MHCC states that “older people may be particularly reluctant to access mental health services because of past negative experiences with the service system, including prejudice, discrimination and lack of knowledge” (MHCC, 2012, p. 68).

The acknowledgement of the impact of assault and bullying is crucial. The suggested method of addressing these problems, however, is limited. While “accepting family” and peer support are important, these are both suggestions that download the responsibility onto the individual, the family, and the community and sidesteps state responsibility for addressing very serious issues of abuse, assault, discrimination, homelessness, poverty, and violence. Framing these problems as primarily affecting youth does not acknowledge that abuse, assault, discrimination, and violence against LGBTQT people is widespread and affects those of all age groups. Likewise, suggesting that “older people” are the ones affected by “past negative experiences” minimizes the

issue by erasing the fact that this affects all LGBTQ people, regardless of age. Moreover, framing the experiences as being in the past suggests that discrimination within the system is largely historical, which is inaccurate.¹⁸

The MHCC then goes on to explain that “stereotypes of all kinds” affect the treatment of LGBT people “within the mental health system and within the LGBT community” (MHCC, 2012, p. 68). The report states that:

On the one hand, mental health service providers must be mindful not to stereotype or discriminate against LGBT people because of their sexual orientation, and also to recognize the impact that discrimination and stigma can have on an LGBT person’s mental health.... On the other hand, LGBT organizations should seek to strengthen their understanding of stigma and other issues related to mental health and mental illness, and be ready to provide support (MHCC, 2012, p. 68).

This acknowledgement of discrimination is positive and stands out in comparison to the section concerning gender, which does not mention discrimination. However, by suggesting that stereotyping can be addressed by being ‘mindful’ not to discriminate suggests that it is a simple matter of reminding service providers as opposed to an issue that requires more systematic and structural forms of intervention. It also reduces the issue to a problem with individual service providers, as opposed to acknowledging that homophobia and transphobia are structural and deeply embedded in the mental health system in myriad ways. For example, simply being ‘mindful’ does not address administrative systems that classify people according to name and gender given at birth,

¹⁸ Discrimination against LGBT people within the mental health system and society is also referred to as a historical phenomenon in *Toward recovery and well-being*, the document that outlines the framework for *Changing directions, changing lives* (MHCC, 2009, p. 44).

causing problems for trans people who have not changed their identification, and often even for those who have, as these systems and those operating them are often not amenable to such changes. This kind of institutional erasure of trans people is endemic (Bauer et al, 2009).

Further, the contrast between mental health service providers being mindful and LGBT organizations learning more about stigma is problematic. The phraseology that begins the sentence about LGBT organizations, ‘On the other hand,’ suggests that it is a commensurate problem to the one regarding mental health service providers. Presenting the shortcomings of LGBT organizations as commensurate with those of the mental health system is inappropriate and unfair, given that LGBTQT organizations do not even exist in many areas of the country, and where they do, are often underfunded by the government. Furthermore, the citation given at the end of this claim is to an article written about the public mental health system in the United States, based on data collected in 1998 and published in 2004 (though incorrectly cited as being published in 2008). This 17-page article devotes 6 sentences to the lack of attention paid to “LGBT people with serious mental illness” by LGBT community organizations. This seems like a dubious basis on which to make claims about Canadian LGBT organizations. In addition, this critique of LGBT organizations stands alone; there are no similar critiques of organizations that serve newcomers, racialized groups, and women.

The MHCC also states that “people who provide mental health services...to the LGBT community need to have a positive attitude and to be knowledgeable about the needs of people from these communities, while at the same time not making global assumptions that can obscure differences among...individual[s]” (MHCC, 2012, p. 68).

Like the recommendation to be ‘mindful,’ the recommendation to have a “positive attitude” makes it a matter of service providers’ disposition rather than a process of challenging deeply held homophobic and transphobic beliefs about LGBTQ people. Given the widespread and structural nature of homophobia and transphobia in the mental health system, the emphasis should be on changing this. Instead, the section includes only one sentence about how providers need to be knowledgeable while resisting “global assumptions.” Yet the MHCC does not say how providers will become more knowledgeable or explain the state’s role in making this happen.

Priority 4.5 ends with four “recommendations for action,” the first being to “increase professional and public understanding of differences in mental health related to gender and sexual orientation” (MHCC, 2012, p. 69). Given that the ‘differences’ described are mostly about the inequitable environments and circumstances that increase or create mental distress, it seems like a misnomer to call this ‘differences in mental health,’ as opposed to ‘differences in privilege’ for example, or even the more neutral ‘differences in mental health needs.’ Characterizing this as ‘differences in mental health’ falls back on the biomedical model and essentializes the problem by locating it within the body, thereby contradictorily ignoring the social factors outlined in the strategy.

The second recommendation, which is to “provide mental health services that are gender and LGBT sensitive,” turns the focus back to environmental factors. It is positive to see acknowledged that there is work to do in the system in terms of making it accessible to ‘LGBT’ people. As demonstrated by the participants’ narratives presented in chapter three, there is a need for training to increase practitioner knowledge about LGBTQ cultures and racialized cultures from anti-essentializing, anti-homophobic, anti-

transphobic, and anti-racist perspectives. Unfortunately, the MHCC does not give any indication about how and where this training will take place, whether in medical schools, hospitals, or doctors' offices, and who will do the training.

The third recommendation is to “take action to reduce the serious risk factors for women’s mental health, including poverty, the burden of caregiving, and family violence.” This is important because it is one of few places in strategic direction four where the MHCC makes mention of the social factors external to the mental health system. However, there is no indication of how this reduction in risk will be achieved. Furthermore, given the fact that the MHCC took pains to outline ‘risk factors’ for both women and men, it seems remiss that there is no mention of men in this recommendation.

Recommendation four is to “improve the capacity of LGBT organizations to address the stigma of mental illness and to work with local mental health services to support their community.” This recommendation is vague, in that it does not specify what “improve the capacity” means. As discussed in chapter three, LGBTQ mental health organizations have excessively long waiting lists for counsellors. This indicates that they are in dire need of more government funding to provide services, not only to address stigma.

With a few exceptions, strategic direction four focuses on increasing access to services, making existing services more ‘welcoming’ to marginalized groups, and challenging stigma associated with ‘mental illness.’ In addition to the erasure of state accountability regarding the creation of conditions that can lead to distress, there is a lack of examination of power relations embedded within the biomedical model such as the ones discussed in chapter three. There is no questioning of who is considered in need of

psychiatric services and why, as well as the ways in which oppressive beliefs are entrenched in diagnostic processes and interactions between service providers and those experiencing mental distress. There is, therefore, no examination of the ways in which recovery may in some cases be hindered by the dominance of the biomedical model. For these reasons, *Changing Directions* does not adequately address what needs to change within the existing system as it stands as well as the possibility of alternative ways of understanding and addressing mental distress and recovery. As a guiding strategy for changing Canadian mental health policy and practice, it runs the risk of further entrenching individualist approaches that leave intact or perpetuate the structural conditions that create distress and hinder recovery. In the next section I seek different answers to these questions in participants' accounts of their good experiences with service providers, their thoughts about what needs to change in the mental health system, and their experiences of community involvement.

Shifting the paradigm in mental health service provision

For the most part, the participants in my study did not make use of the word 'recovery'; nor did I use this word in talking with them. Instead, they discussed the ways in which they handled their distress, whether through medical strategies or otherwise. While some participants felt that the distress they had experienced was in the past and unlikely to recur, others characterized their distress as something that was ongoing and changed over time, according to life circumstances. Many discussed their individual strategies for addressing distress, but it became evident that this concerned more than what they could do as individuals and was structured by what took place inside and outside the mental health care system. As evidenced in chapter 3, the mental health

system often contributed to or increased participants' distress. At the same time, some found supportive and respectful services, often (though not exclusively) within community health care services. These accounts of good experiences as well as participants' thoughts about what needs to change in the system contrasts sharply with the MHCC's conceptualization of conditions that facilitate recovery.

One of the recurring themes in participants' narratives about their positive experiences with service providers was the importance of active listening skills, respect for participants' choices, and supportive counsel. Allison, a Torontonians who identifies as white, queer, and genderqueer, said about her good experiences with counsellors in Toronto: "They listen to you. They sit there and they listen to you and they don't really judge you, at least I don't think they do. If they do, they shut up [both laugh]. They do it privately." Similarly, Viki, a racialized, queer, gender-fluid woman, described her experiences with counsellors in Toronto as positive and very different from her experiences with psychiatrists: "I've been fortunate to have really great counsellors who I've connected with and have challenged me, helped me unlearn things, and also really validated, which is the opposite of what I feel when I go see a psych. It's the opposite of validation. It's feeling like shit."

Displaying skills such as listening, respecting agency, and being supportive may seem like simple requirements, but it indicates a paradigm shift in the way that many practitioners are currently operating. One participant from Winnipeg, Bettie, a white, queer, cisgender woman, described this as follows:

I think that mental health providers are super paternalistic and think that they know the right answer and the best thing for people and don't acknowledge

context as much as they should be acknowledging context. I think they should be seeing their patients as allies and not as patients. I think that is a new kind of concept in healthcare where you don't have clients or patients. You have an ally and somebody that you work with to support.

A shift from envisioning people as patients to allies would mark a paradigm shift because of the implications about power relations. As Bettie suggests, equitable power relations between practitioners and those experiencing mental distress would alter problematic paternalistic dynamics, as discussed in more detail in chapter three.

Another theme that arose from the participant interviews was the importance of having service providers who addressed their social contexts. For example, Jen, a white, pansexual, cisgender woman, told me about a social worker in Toronto: "The social worker was very crisis management. She was looking a lot at the social factors that were impacting me at the time. And she was great. I really appreciated her. She really understood youth and she really got where I was coming from [at] sixteen."

Likewise, Raven, a Métis, trans, genderqueer person, was connected with a lesbian mental health worker and a gay youth and family development worker in Winnipeg as a teenager. These two workers helped him access social assistance and living arrangements. They also served as advocates for him within the mental health system. Raven shared what happened with one of the workers after a particularly oppressive experience with a doctor:

I told her about it and she was like, 'That asshole.' She's like, 'I'm going down there right now.' She opens her purse, applies her lipstick and takes off, went over

to the clinic and fucking reamed them out. Like the doctor, the manager, she filed a formal complaint for me. It was amazing.

After this experience, Raven never had trouble with that doctor again. This kind of advocacy is incredibly important. As an Indigenous genderqueer youth navigating the child welfare system and the mental health system, Raven experienced a lot of oppression. He felt that because these two workers were queer, they were motivated to help him and they were the ones he “talked to and connected with the most.” He was still in touch with one of them as an adult and named her as “a really, really strong queer person in my life.” This kind of advocacy is very different from medicating someone and sending them on their way and was far more helpful in aiding Raven with addressing some of the conditions in his life that were creating distress. The needs identified by the participants for service provision that treats people as allies, is supportive, and provides advocacy that addresses social contexts stands in contrast with the needs identified by the MHCC, which concentrates on ‘risk factors’ associated with being a member of marginalized groups.

Participants also emphasized that there is only so much individual workers within the system can do. If social factors are to be taken seriously as causes of mental distress and therefore an important site of intervention in recovery efforts, structural changes are necessary. This requires shifting the focus from individuals to structures. As Jacobsen et al (2010) state, “recovery should focus more on addressing social inequities and changing systems of mental health services and supports and less on changing the individuals who use these services and supports” (Jacobson et al, 2010, p.13). This structural focus must reconfigure recovery using a broad lens. As Weisser, Morrow, and Jamer (2011) argue,

“mental health recovery services” should “include social supports such as housing, income security, employment options, accessible transit systems, paid parental leave, language classes, and educational opportunities” (p. 26). Likewise, Harper and Speed (2012) contend that more attention should be paid to identifying the “structural facilitators of recovery” such as “stable income, good housing, [and] employment” (p. 22). As this suggests, mental health recovery needs to be perceived in very broad structural terms in order to adequately address the social causes of mental distress. As outlined above, the MHCC minimizes structural factors, particularly those involving state responsibility.

Another recurring theme from participant interviews is the importance of having a social justice approach to mental health service provision. This requires having knowledge of the ways in which power relations structure social inequities, processes of marginalization, and impacts of colonization, abuse, trauma, oppression, and violence. This goes beyond having a static understanding of ‘diverse cultures’ and populations as is proposed by the MHCC’s suggestion of cultural competence training. As described in chapter three, many practitioners continue to pathologize LGBTQ sexualities and gender identities. In order to combat these issues, some participants believed that practitioners need to be aware of the history and ongoing practice of pathologizing LGBTQ cultures and identities and how this may impact LGBTQ people who experience mental distress. As one Winnipeg participant, Rob, a white, French-Canadian, queer, gay, cisgender man, told me, “gender and sexual identity that doesn’t fit into the norms of society” have been considered mental illness and in some cases continue to be seen as such. He stated emphatically: “We can’t operate in that way anymore and so I think there are definitely

specific sensitivities required for a community that has for a long time been associated with mental illness in a really non-helpful way.” Rob believed that service providers becoming educated about this might make the mental health system more accessible to LGBTQ people.

Many participants discussed the importance of service providers learning to place the focus on the effects of discrimination, rather than on sexuality, gender identity, and race as suggested by the MHCC recommendations. Barry, a white, gay, cisgender man in Winnipeg, believed that service providers need to be knowledgeable about the health impacts of any kind of discrimination. He discussed how service providers need to take the effects of experiencing this kind of “hate” seriously. As he said: “I would say not just LGBTQ, I would also say anyone who’s experiencing widespread hate I think would really be detrimental to your health to be told just for existing you’re wrong and you’re a terrible human being.” Likewise, Aaron, a racialized, gay, cisgender man in Toronto, emphasized that service providers need to understand how “isolation and the shaming and the way people are conditioned to feel really uncomfortable in their own bodies requires more work to accept on the part of LGBTQ people.” Aaron stated that it was very important to accentuate that LGBTQ people don’t “need more mental health resources because they’re LGBTQ but because of the way they’re made to be ashamed of themselves.” Similarly, A.P., a racialized, queer, cisgender person in Toronto, stated that regarding gender identity in particular, service providers need to understand that “being transgender is not a mental illness and then in turn, there’s nothing wrong with having a mental illness.” This is in sharp contrast with the MHCC’s approach, which reminds service providers to be ‘mindful’ and have a ‘positive attitude.’

Many attributed the ability to use a critical approach to LGBTQ mental distress to having experiential knowledge of marginalization. As one participant, Devon, a white, queer, trans man in Toronto, said, there is “very limited breadth of knowledge or experience” about race, class, sexuality, and gender amongst practitioners. He believes that this problem is not easily solved. As he said: “I don’t know if you could read an extra chapter on queer stuff and then suddenly be the greatest doctor ever.” For Devon, understanding was achieved through experience: “I think it’s experiential in a lot of ways. Unless you are queer or have a queer family member, been in proximity to it over a great length of time, then you can’t really relate.”

Likewise, Mike, a white, omnisexual, trans man in Toronto, found that a lack of “commonalities” between himself and the practitioners he had seen made the interactions “cold and distant” because practitioners are not “personally relating to the person, or if they do it seems really fake because there’s no real commonality that they necessarily share.” Mike found that service provider efforts to relate to him were not only fake but sometimes “offensive” because “the examples that they’re drawing on are so radically simplistic compared to what I’m talking about.” Mike had never encountered a service provider who shared key commonalities with him and believed that this would have made a positive difference in the interaction.

Likewise, some racialized participants discussed the importance of seeing racialized service providers. Marcus, a racialized, queer, trans man in Toronto, said that he was helped by seeing a racialized counsellor who was “really good with the race issue.” He found that when he discussed race and racism with white counsellors, he did not feel understood and stopped sharing these experiences. Similarly, Laila, a racialized,

queer, cisgender woman in Toronto, told me that “the biggest thing” was race, because “that’s the thing they see.” She also considered disability an important factor and believed that seeing a racialized, disabled counsellor may have made a positive difference in her counselling experience because “possibly people [counsellors] wouldn’t be so quick to make assumptions based on that.” She acknowledged that this was “not necessarily true” but hoped this would be the case.

This desire for service providers who share commonalities in terms of social location can be seen as essentialist. Social difference is defined across a number of intersecting fronts, including but not limited to age, sexuality, gender, race, class, and disability, and none of these are static, fixed categories that share essential commonalities (Valentine, 2002). There is no guarantee that LGBTQ practitioners will have anti-racist, anti-oppressive perspectives or share commonalities with LGBTQ people seeking services. While lived experience is often the catalyst that leads people to learn social justice perspectives, it is possible to develop a critical consciousness through education without life experience of marginalization.

However, it is important to understand some participants’ preference for practitioners who are perceived to be similarly socially located in some way within the larger context of oppression in the health care system. As discussed in detail in chapter three, many service providers do not have a critical consciousness and continue to pathologize people on the basis of gender, sexuality, and race. In this context it is understandable that participants would hope that practitioners with lived experience of marginalization may be better informed than those who do not. Additionally, perceived social location affects relationships between providers and those seeking services in that

it often has impact on trust level. One of the cumulative impacts of experiencing oppression at the hands of health care practitioners is that some participants were less likely to trust practitioners they perceived as having privilege based on their social locations. For example, A.P., quoted above, said that it “means a lot” for her to be able to discuss her “problems” to “someone who isn’t straight” because if she is unsure of their sexuality she does not feel comfortable sharing her experiences. When I asked her to elaborate on the reasons for this, she told me that heterosexual practitioners are likely to make heterosexist assumptions and be unable to “relate” and to “get it.” Likewise, Lisa, a white, Portuguese, French-Canadian, lesbian, queer person, did not feel comfortable with her male counsellor: “I just didn’t feel that he could connect with me. The lesbian issues are not the same as straight man issues.”

As the participants’ comments indicate, there is a need for more access to LGBTQT practitioners and practitioners with a critical consciousness, along with practitioners who have experiential knowledge of oppression and marginalization and who have social justice approaches to service provision. While such practitioners can also be found in private practice, many people cannot afford their services. For this reason, it is necessary that provincial health insurance be expanded to include those who are currently considered private practitioners. As indicated by chapter three, there is also a need to better train service providers within the mainstream mental healthcare system. As the participants’ comments demonstrate, this training must go beyond the cultural competence approach suggested by the MHCC and should be considered essential to providing mental health services.

Participant accounts suggest that there are significant changes that need to take place in the mental health system that are not accounted for by the MHCC strategy document. Furthermore, the shortcomings described by the participants are in many ways characteristic of the biomedical model of ‘mental illness’, as detailed in chapter three. This suggests that biomedicalism does not always facilitate ‘recovery,’ something that is not considered in *Changing Directions*. This also indicates that there is value in exploring options outside of medical methods of dealing with distress. The following section discusses community building and participation in an effort to indicate the existence of alternative sources of support and non-medicalized forms of ‘recovery’ for participants. This is not to suggest that the responsibility for ‘recovery’ and support should be placed on LGBTQ communities; nor do I argue that such communities are utopian spaces free of problems. Rather, this discussion aims to broaden the narrow vision of ‘recovery’ offered in *Changing Directions* and to explore the perspectives of LGBTQ people with lived experience regarding alternative means of support in Toronto and Winnipeg.

Recovery as a “collective journey”

Weisser, Morrow, and Jamer (2011) argue that recovery should be seen as a “collective journey” rather than a personal one and should include “building a sense of community, using preexisting support networks, fostering family and cultural connections where desired, and overcoming social isolation” (p. 26). Their examples of collective recovery are “political activism” and “connection with one’s culture” (Weisser, Morrow, & Jamer, 2011). Following this reconfiguration of recovery as collective, connections to LGBTQ and other social, cultural, and political communities could be viewed as part of a collective journey of recovery. Indeed, many participants named

communities as places of support and as part of addressing mental distress. For example, Brock, a white, gay, cisgender man in Winnipeg, stated that the idea that “everyone’s responsible for their own mental health is too much along the same lines of the rugged individual surviving in the wilderness.” Brock believed that this is not an accurate depiction of “how people function, as social creatures.” For Brock this meant that “there really needs to be less of an institutionalization of mental health and more of a grassroots community focus.”

Many participants identified isolation as a factor that created and exacerbated mental distress, while they saw connection with community as an antidote. For example, David, a white, Jewish, gay, cisgender man in Winnipeg, said: “I think when people are isolated, that’s the worst possible thing. If we’re gonna talk mental health, isolation is one of the key issues. Whether you’re isolated socially, medically, whatever, when you’re on your own and you don’t feel connected up, you’re gonna get sick.” Connecting with community may be especially salient for LGBTQ people, who often experience discrimination within family settings, reducing the amount of available support. As Smith, a white, queer, trans man in Toronto, said: “I think it’s still pretty common as queer and trans people that we don’t have the support from our families of origin that we need. And so creating those things is a pretty big part of what I want my community to be.”

Participants in both Toronto and Winnipeg were involved in community building and community engagement as part of addressing mental distress, though this took different forms in each city. Toronto’s large size and diverse population offered more opportunities for creating various kinds of communities. Toronto is perhaps unique in this

respect amongst Canadian cities; even large cities like Vancouver do not quite compare. For example, one participant, Devon, quoted above, moved to Toronto from Vancouver and found that the social landscape was quite different:

When I first moved here I started hanging out with a lot of trans guys, because that was also new. I didn't hang out with as many trans guys before because there just wasn't as many; there was three or four of us. But now here [in Toronto] it's like you can meet ten right away and then there's ten other guys who hate those ten guys [laughs]. Like there's just so many more people.

As Devon's comments indicate, the sheer number of people in Toronto makes it more possible to have community based on identities, behaviours and experiences (such as being trans) that are often marginalized within gay and lesbian communities. For many, this was a crucial part of addressing mental distress. For example, Viki, quoted above, discussed connections to Toronto communities that "are more open to certain differences," such as the "BDSM kink community" and the "poly community," as an important part of dealing with mental distress. As she said: "I can talk freely about my mental health stuff. And I use that as part of addressing some mental health things I'm going through." Likewise, Mike, quoted above, named the Toronto "BDSM leather community" as a place where people can deal with "deep problems":

People will have problems, like deep problems that they need to work out and live through and they have tactics for dealing with them that are definitely not within how you're supposed to deal with your issues. So I think that community is most aware of the diversity of people. So they don't expect everybody to be the same.

Mike also named the Toronto “HIV/AIDS community” as a supportive place to deal with mental distress: “Similar to BDSM and leather, people are more real and deep when they’re in a safe environment. In the sense that if you’re in a room with people that all know that they can trust each other, people will go a lot further. Those rooms are very valuable.”

Some participants, like Aaron, quoted above, found community through LGBTQ organizations or groups. His involvement in a LGBTQ student group at a university offered “validation” and “a space where I could not constantly be questioned and made to feel like I’m strange or fucked up.” Likewise, Derek, a racialized, queer, genderqueer person, found that participating in Trans Youth Toronto, run by the 519 Community Centre, fostered a connection with one of the facilitators, who “checks up” on him regarding “mental health” and “disability.”

Other participants, like Allison, quoted above, had friends who served as a source of community and support:

I have friends who are consumers of the psychiatric system and we do create a small community for ourselves where we can talk about this stuff, we can be open about it and it’s not stigmatizing. And we do support each other. There’s maybe three or four of us, but it’s one way that we can feel like we’re supporting each other and we get it, because most of us are queer.

Shared experience of both mental distress and being queer allowed for a valuable form of support for Allison and her friends. Similarly, Marcus, quoted above, was part of a group of queer and trans people who met regularly to discuss community accountability. This

group was interested in figuring out a way to do “collective care” regarding mental health, which he described as follows:

I feel like mental health is not really talked about as much, but in the community accountability group we are talking about it a lot. We’re talking about disability, collective care, which is kind of new to me but I think it’s an amazing concept, and a lot of people talk about things that they need to do for themselves, plus what they do if they need to outreach the community with collective care. Some people feel like they need collective care and some people need to self-isolate – we’re just getting into the whole discussion about that.

Marcus was excited to encounter the concept of collective care as a way of addressing mental distress on a community level. Similarly, Smith, quoted above, discussed being part of a “care collective” for “people with depression or who are going through grief” and noted that this was a “community that’s created around being support systems for people.” As Marcus’s and Smith’s stories show, there are subgroups within Toronto LGBTQT communities that are interested in radically reconfiguring support for mental distress as a community effort.

As these participant narratives demonstrate, creating and participating in community plays a crucial role in addressing mental distress. However, the creation of such communities seemed hard-won and the communities remained marginalized. Many participants referred to ‘mainstream’ queer communities where various kinds of oppression ran rampant, leaving them feeling isolated. For example, Aaron, quoted above, described staying quiet about his attraction to “chubby men” because the existence

of fatphobia made people more “freaked out” by his attraction to fat bodies than by his attraction to men.

In addition to fatphobia, many named the prevalence of racism, ableism, and classism as exclusionary forces within LGBTQT communities. A.P., a racialized, queer, cisgender person, described this as follows:

The mainstream queer spaces tend to be super, super white. And it’s the kind of thing that I used to be more comfortable with but not anymore. So it’s like, okay I could go but none of the other queer people I know would feel welcome. With disability stuff once again, like, why is everyone white? Or there’s an awful lot of straight people, and so on. So it’s hard to find people that I have a lot of stuff in common with, identity wise.

A.P. also described a lack of interest within mainstream queer communities in making events accessible and a lack of acknowledgment that “disability intersects with poverty.” Similarly, Laila, quoted above, described an event that was advertised as being created by and for disabled queer people, but was “really exclusionary” because it was “such a mainstream kind of queer,” not physically accessible, and featured an MC who made ableist and racist jokes, such as making fun of a performer with a “non-Anglo name.” For Laila, experiencing this kind of event meant that she felt isolated and no longer sought out community:

The worst part was that I was hoping and looking forward to some kind of community space, and it was just such a huge disappointment. Another reason why I avoid getting into these kinds of spaces, because of shit like this. It’s just such a huge, crushing disappointment.

Laila's story highlights the importance of supportive, anti-oppressive community by illuminating the impact of experiencing the opposite. Likewise, Viki described being asked to stop attending meetings of a community of women of colour based on her physical and mental health. She was unable to attend some meetings due to her physical health and was sometimes "checked out" when she was present due to her mental health. Viki was deeply hurt by the ableist and sanist request to leave the community: "I'm still really, really struggling, like not a day goes by that it's not painful." As these stories show, creating community that was inclusive and anti-oppressive in every respect was an ongoing struggle in Toronto.

This was also a challenge in Winnipeg. Winnipeg is the largest city in Manitoba and is larger than the second largest city, Brandon, by approximately 68, 000 people. This makes Winnipeg, at 700,000 people, a 'big city,' but on a much smaller scale than Toronto. The small size of the Winnipeg LGBTQ community meant that there were fewer anti-oppressive community spaces and events. There were fewer opportunities for what one participant, Raven, quoted above, called "radical queer community." As he also pointed out, much of the Winnipeg LGBTQ community is a bar-based culture:

The main queer community is really the bar scene, especially in Winnipeg. In bigger cities you definitely have more options, but in Winnipeg it's pretty small. There's not like a radical queer community. It's mostly just the bar scene and then friends. So I have friends. But I've never really felt a part of any queer kind of scene or whatever.

Bars are generally inaccessible spaces for many reasons, including the centrality of alcohol, physical inaccessibility, and conditions (like crowds of people and loud music)

that can be difficult to navigate for some who experience mental distress. As Raven points out, bar culture is not particularly amenable to ‘radical queer community’ where alternative forms of support can be organized, such as the collective care arrangements described by Toronto participants.

Racism also made some Winnipeg LGBTQT community spaces hostile places for racialized participants. At the time of interviewing, there were two queer bars in Winnipeg, Gio’s and Club 200. As Travis, quoted above, told me, these bars had “very, very different clientele”:

I don’t think a lot of the clientele [from Club 200] would feel comfortable or even be allowed to get into Gio’s, because a lot of the clientele from Club 200 is primarily Aboriginal, two-spirited, some trans folks. Whereas Gio’s is much more non-Aboriginal. I’ve heard people talk about it in the community, right. I’ve heard people be like, ‘I’m not going to Club 200. There’s too many Indians there.’

As Travis points out, racism towards Indigenous people created exclusionary social spaces. Another participant, Sonja, a Métis, bi-queer, cisgender woman, told me that “community celebrations” that take place at Gio’s are often avoided by people of colour, because they are “very centred around white privilege.” Sonja gave an example of a drag event that she described as “Pocahontas, John Smith fucking pow wow party shit.” The organizers defended this racist, colonialist event on the basis of having included an Indigenous drag performer who was apparently “fine with it.” Sonja was angry that the organizers used this tokenistic defense. She said that many people in the community were oblivious to how racist these kinds of events were and that “the only people who are aware of how weird it is to have that kind of celebration are the people of colour who

avoid it.” As Travis and Sonja suggest, Indigenous LGBTQ people experience racism within LGBTQ communities, making some community spaces sources of exclusion rather than support. However, their comments also suggest that Club 200 provided a more supportive place for Indigenous LGBTQ people, though this was not addressed directly by any of the participants.

In addition to LGBTQ bars, LGBTQ organizations and mental health organizations were mentioned as problematic sources of community. Some felt that LGBTQ organizations were not particularly inclusive of those who experience mental distress and that mental health organizations were not inclusive of those who are LGBTQ. As Andrea, a white, queer, cisgender woman, said: “There’s not really any support systems as far as I’ve noticed. They’ll either support your crazy or they’ll support your queer.” Likewise, Barb, a white, lesbian, woman, told me that the LGBTQ community and the “mental illness” community “run parallel to each other” and are not “necessarily integrated.” This meant that those who sought support from mental health organizations such as through the support groups run by the Canadian Mental Health Association found that there was a singular focus on mental health. For example, Angela, a white, gay, cisgender woman, found support by attending support groups for people who shared her diagnosis: “It made me feel more okay in my skin, hearing other people’s stories that, you know, they have grandiose episodes too. That they think they’re Jesus [laughs]. It’s good to identify with.” This support was incredibly important for Angela, but she found that there were no groups “specifically for the gay population.” Likewise, Lisa, quoted above, attended support groups for those who shared her diagnosis and found them to be helpful, but was told that it was not “appropriate” to discuss anything

pertaining to her sexuality. This left her feeling like she could not be her full self and that there was no place where she could “let both out” and “be safe to do that, and feel safe.” As in Toronto, participants struggled with oppression within community spaces and with finding and creating space that was fully inclusive and anti-oppressive.

However, the small size of Winnipeg LGBTQT communities had some positive effects in terms of making connections and creating support. Many felt that the small size made it more conducive to finding community through friends. Crabitha, a Métis, lesbian, cisgender woman, told me that the Winnipeg community is “so small that it’s more like one on one.” For her, this provided the opportunity to connect with other LGBTQT people who experience mental distress. She said: “You know who has mental health issues. Maybe not everybody, but you start to know some people who have [pauses] like the person who you’re interviewing tomorrow. I know her and we talked about this thing over the weekend.” For some, like Crabitha, the smallness allowed for making connections. Likewise, Stacey, a white, queer, person, found that seeing the same people over the course of many years in the queer community meant that she eventually came to know others who experienced mental distress through talking more “deeply” with people in the community. This allowed her to create a supportive community of queer friends who also experience distress and reject medical methods of addressing it:

It provides a basis of support for people. I’m also a manic depressive, up and down all over the board. And for the group of people that were having the same types of things going on, there’s certainly a support in that because you can recognize what’s going on and you can recognize what’s happening in your drug cycle. It’s an odd community support system but it works. Because your friend

would see what was going on, and instead of taking you to the doctor or to wherever you'd get a shot, you'd do some drugs and you'd be fine.

For Stacey and her friends, taking drugs that are often deemed 'recreational' instead of psychiatric drugs was part of addressing mental distress. Doing this within a group of friends offered a way of monitoring her moods and considering how the drugs were affecting her.

For some, like Stacey and Crabitha, the small size of the community had positive effects, like making it easier to find and connect with LGBTQ people who experience mental distress. However, the small size of the community also created challenges, like harmful gossip and lack of privacy. Lisa told me that the Winnipeg community was "too small" for her to seek out mad queer community. She believed that having people know about her mental distress would lead to gossip and isolation rather than connection:

It's bad enough that being in the gay community, you sleep with someone and it's told that you slept with the world. I cannot begin to imagine the words that would come out of certain individuals' mouths about Lisa being crazy or having borderline personality disorder. 'Personality what?' I just, I can't even. So it's because of not wanting other people to know, not wanting to have to deal with a small community, I've limited myself because I don't want to go through people talking about me and it getting back to me. I can't deal with that.

Lisa had already experienced negative judgments in the LGBTQ community regarding her sex life and believed this lack of understanding and gossip would extend to a discussion about her mental health. She therefore felt isolated from the LGBTQ community.

As this discussion shows, many participants in both Toronto and Winnipeg believed in the importance of community participation as a crucial component of addressing mental distress. Community building and participation in both cities was complicated and often fraught with tensions regarding various kinds of oppression. However, it was clear that connection with others and support from people who have similar experiences was key in dealing with mental distress.

This is not to say that community participation should take the place of government-funded initiatives to address mental distress and promote ‘recovery.’ This is important to note because the reconfiguration of recovery as collective could be just as compatible with neoliberal agendas that sidestep state responsibility as is the case with the currently popular ‘personal journey’ of recovery, which downloads responsibility onto individuals and communities. Rather, I am suggesting that it is possible to learn from those with lived experience about what ‘recovery needs’ are met by community building and participation with an eye for what might be lacking within biomedical ideology and practice, and therefore what could be changed in order to meet those needs. For example, from the participant stories quoted above, it seems like community building and community engagement offered validation, understanding, support, respect, and alternatives to medical methods of dealing with distress. In many ways this echoes what was identified as lacking in the mental health system. This is not meant to provide definitive answers or alternatives, rather to offer some preliminary thoughts based on the participants’ perspectives and experiences with community building.

In this chapter I critiqued Canada’s mental health strategy for failing to advance a strong structural analysis of the social conditions that can lead to mental distress. I argued

that this is accomplished through positioning such conditions as ‘risk factors’ associated with marginalization, rather than at least partially created and perpetuated by the state. In addition, participant narratives show that there is much to consider in terms of the failures of biomedical approaches to recovery, which are not examined in *Changing Directions*. Participants’ stories about community involvement offer one way to begin an exploration of other ways to think about recovery. This raises important questions for further consideration as to how to foster the positive effects of community building and participation as part of ‘recovery’ as well as implementing structural changes that would meet these needs within the mental health care system and beyond. This would require resisting the MHCC’s neoliberal appropriation of ‘recovery’ as a ‘personal journey’ and encouraging state accountability for creating conditions conducive to addressing mental distress (Morrow & Weisser, 2012). It also requires further exploration of non-medical approaches to recovery in order to truly ‘change directions’ in Canadian mental health care.

Chapter Five: (In)visibility in the Workplace: Navigating Disclosure and Intersectional Oppression at Work

In the last chapter I examined Canada's mental health strategy document, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. I argued that this document puts forth a limited analysis of the relevance of race, gender, and sexuality in terms of recovery, and minimizes the state's role in producing the structural conditions that can exacerbate or create mental distress. The rise of recovery as a foundational concept in mental health policy has created new interest in the possibility of employment for those who experience mental distress. Indeed, employment can contribute to recovery through providing opportunities for social inclusion, friendship, financial gain, and self-esteem. Conversely, the workplace can be exclusionary and oppressive and create or intensify mental distress. The workplace is therefore an important arena to examine.

In this chapter I draw on my interview data about employment as well as scholarly work regarding 'invisible identities' to analyze the participants' workplace experiences. I position mental distress, sexuality, and gender identity as aspects of the participants' lives that are sometimes invisible and as such require decisions about 'coming out' in the workplace. I show that even those who are visible or who have disclosed information about experiences of mental distress, sexuality, and gender identity face ongoing decisions about disclosure. I argue that such decisions are particularly pressing and high risk at work, given the economic stakes, the effects on health and well-being, and the prevalence of oppressive beliefs and practices in the workforce. I challenge the positioning of mental distress, sexuality, gender identity, and race as personal, private, and neutral social differences by examining the role of sanism,

homophobia, transphobia, and racism in structuring the participants' work lives, including obtaining and retaining work, evaluations of job performance, and access to workplace accommodations. I conclude with some recommendations regarding the improvement of workplace conditions for LGBTQ people who experience mental distress. As in other chapters, I did not find significant differences between the participants located in Winnipeg and Toronto and they are therefore discussed as a group.

The importance of employment

The psychiatric survivor movement has long claimed that employment can play an important role in well-being, as captured by the adage “a home, a job, a friend” made popular by Canadian psychiatric survivor activist David Reville in the 1990s as a simple way to describe commonly unmet needs of those who experience mental distress (Reville & Church, 2012, p. 192). Indeed, Beckman and Davies (2013) contend that “next to homelessness, unemployment and the specter of poverty are the biggest practical problems facing people with psychiatric labels” (Beckman & Davies, 2013, p. 54). Psychiatric survivor activists have challenged biomedical deficit model narratives that position ‘mentally ill’ people as incapable of meaningful employment and have argued that many who experience mental distress are capable of and can benefit from employment (Repper & Perkins, 2003). Activists and scholars have drawn attention to the ways in which employment can help with increasing self-esteem, recuperation of a sense of self outside of being labeled ‘mentally ill’, as well as the obvious financial benefits (Boardman, Grove, Perkins, & Shepherd, 2003; Church, 2001; Cohen et al., 2008; Davidson & Strauss, 1992; Dunn, Wewiorski & Rogers, 2008; Provencher, Gregg, Mead, & Mueser, 2002). Indeed, some preliminary research indicates that participation in the

workforce may reduce the amount and frequency of hospitalization and the need for mental health services (Cohen et al 2008, p. 7). It is important to acknowledge, however, that employment is a social factor that can exacerbate and cause mental distress; most jobs are not structured to ‘accommodate’ those who experience mental distress; in fact able-bodied expectations are the norm (Honey, 2004).

The mainstreaming of recovery as a key concept in mental health policy and service provision has resulted in an increased interest in the role of employment in successful recovery from mental distress (see for example, MHCC 2012). While the psychiatric survivor movement has focused on the aspects of employment that can be beneficial to those who experience mental distress, mainstream perspectives tend to focus on the impact on the economy. Media stories, government publications, and some scholarly work often positions ‘mental illness’ as a ‘drain’ and a ‘burden’ on the economy (Bradley, 2014; Hilton, Scuffham, and Vecchio, 2010; Kirky, 2012; Koerner, et al, 2004; Lim, Jacobs, and Ohinmaa, 2008, MHCC, 2011; MHCC, 2013). Increasing employment rates amongst those deemed ‘mentally ill’ is thus framed as an important measure to reduce the amount of money that is ‘lost’ due to lack of productivity. As Poole (2013) points out, in this formulation “the reason sickness is undesirable is not that it causes distress or discomfort but that it results in what is often called ‘lost productivity.’ This is a sinister and absurd notion, predicated on the greedy fallacy of counting chickens before they have hatched” (Poole, 2013). Poole goes on to argue that “the idea seems to be that business already has that money even though it hasn’t earned it yet and employees who fail to maintain “productivity” as a result of sickness or other

reasons are, in effect, stealing this as yet entirely notional sum from their employers” (Poole, 2013).

Further, the economic burden narrative is based on ableist ideology that places the blame on those who are excluded from the workforce rather than analyzing the structural conditions that make it difficult or impossible for everyone to participate in paid work, as well as employment conditions that can create or contribute to ill health. This chapter examines one such factor, intersectional oppression, but it is important to note that there are many other structural factors that affect employment conditions that are beyond the scope of this study. These include the effects of minimum wage regulations, immigration law, precarious employment conditions, disability and social assistance regulations, and the continued existence of sheltered workshops or ‘work programs,’ where workers deemed ‘mentally ill’ are paid well below minimum wage.

Employment and LGBTQ people who experience mental distress: An overview

Disabled people have long experienced discrimination in the Canadian workforce. Schier, Graham & Jones (2009) argue that full inclusion of those with disabilities in the Canadian labour market would require major change in both “corporate and societal attitudes” (p. 70). Mad people in particular have a long history of exclusion from the paid workforce as well as exploitation of their labour (Reaume, 1997; Reaume, 2006). Many mad people in Canada continue to live in poverty (Wilton, 2003) and, according to the Canadian Mental Health Association (CMHA), the percentage of those with “serious mental illness” who are unemployed is between 70 and 90 (CMHA, 2012). Yet 80% of people with “serious mental illness” want to be employed (Canadian Mood Disorder Society, 2009).

These statistics suggest that there are significant obstacles preventing people who experience mental distress from obtaining and maintaining work. The CMHA identifies some of the obstacles facing those with “psychiatric disabilities” as “gaps in work history, limited employment experience, lack of confidence, fear and anxiety, workplace discrimination and inflexibility, social stigma and the rigidity of existing income support/benefit programs” (CMHA, 2012). The Canadian Mood Disorders Society reports that 64% of Canadian organizations “have no structured process for supervisors to support employees’ return to work after *any* illness or disability” and only 20% of organizations see addressing “stigma associated with mental illness as a priority” (Canadian Mood Disorder Society, 2009). Despite these dire statistics, there are few Canadian studies regarding workplace equity and disability, including mental health (Peters & Brown, 2009; Shier, Graham & Jones, 2009).

In terms of sexuality, Hunt and Eaton (2007) claim that Canada is a “queer-positive nation” with “one of the most progressive records on sexual diversity issues in the world” due to anti-discrimination law and the legalization of ‘same-sex’ marriage (pp 130-131). The Canadian labour movement has been instrumental in creating social change for lesbian, gay, and bisexual people in the workplace, including the extension of benefits to ‘same-sex’ partners and non-discrimination provisions (Hunt & Eaton, 2007). Hunt and Eaton (2007) argue that the changes made by unions influenced non-unionized organizations to do the same and “made the idea of expanding coverage into human rights codes less alien to...some legislators (p. 138). In terms of trans rights, labour has been slower to respond and implement anti-discrimination provisions in collective agreements, “nor has there been much indication...of social acceptance at the grass roots

of the union movement,” though the Canadian Union of Public Employees (CUPE) has made inroads (Hunt & Eaton, 2007 p. 153). Further, the Canadian labour movement still has much work to do in terms of addressing racism both within the movement and the workforce (Das Gupta, 2007; Galabuzi, 2006; Rayside, 2007). This is also the case concerning disability rights (Rayside, 2007. p. 214). However, as Rayside (2007) notes, there is much to be learned about how effectively anti-discrimination policies have been put into action and “with what impact at the local level” (p. 153).

Indeed, the efficacy of anti-discrimination policy is an important consideration. Writing in an American context, Spade (2011) argues that anti-discrimination law individualizes discrimination and fails to address structural oppression. As he states,

Anti-discrimination law seeks out aberrant individuals with overtly biased intentions. Meanwhile all the daily disparities in life chances that shape our world along lines of race, class, indigeneity, disability, national origin, sex, and gender remain untouchable and affirmed as non-discriminatory or even as fair” (p.85).

Spade (2011) cites the continued existence of “wage gaps, illegal terminations, hostile work environments, hiring/firing disparities, and bias-motivated violence” towards marginalized groups as evidence of the inefficacy of anti-discrimination law (p. 82). Further, he contends that such laws protect “the least marginalized of the marginalized” (usually white people with professional jobs and immigration status), while failing to protect those who “face the worst economic vulnerability” such as racialized, disabled, trans people without legal immigration status (Spade, 2011, p. 87). Though Spade is referring to anti-discrimination law in the United States, his arguments provide insight into the way such laws operate in Canada.

One way to approach the question of how effective anti-discrimination policies have been is to look at income differentials. Is there a “financial penalty for being gay” in Canada as there is in the United States? (Badgett, 2003, p.10). While income differentials between heterosexuals and gays and lesbian (though not bisexual, queer, and trans people) have been documented in the United States, Canadian studies are limited in number. In a report commissioned by the Canadian Aids Society, Ryan (2003) speculates that Canadian income differentials for gays and lesbians are similar to those in the United States, where gay men make less than heterosexual men and lesbian women make slightly more than heterosexual women, but less than gay men (p.14). He also surmises that lesbian, gay, and bisexual refugees, newcomers to Canada, and two-spirit Aboriginal people are especially likely to be low income but due to a lack of research in this area, does not have evidence. (Ryan, 2003, p. 15). Carpenter (2008) provides the first, and to date the only, Canadian study examining the links between “sexual orientation” and “economic outcomes” (p. 1). Based on the 2003 and 2005 Canadian Community Health Surveys and the 2001 Canadian Census, he concludes that gay men do indeed have lower incomes than heterosexual men, while lesbian women make more money than heterosexual women because they work more (whether this is still less than gay men is not mentioned) (Carpenter, 2008).

Income disparities are not the only means through which lesbian, gay, bisexual, and queer people experience discrimination. A Canadian poll conducted by Angus Reid in collaboration with the Canadian Gay and Lesbian Chamber of Commerce showed that “one in 10 LGBT workers still find coworkers and employers intolerant of their sexual orientation, and between one third to half of respondents had experienced some form of

discrimination throughout their professional lives” (Angus-Reid, 2011). More specifically, Bowring and Brewis’ (2009) qualitative study about lesbian and gay workplace experiences in Ottawa, Vancouver, and Montreal suggest that gays and lesbians who are also gender non-normative may have a more difficult time navigating the workplace and that those in long-term relationships were seen as more acceptable to their heterosexual colleagues (Bowring & Brewis, 2009). They conclude that “lesbians and gay men who perform in ways *closest to* prevailing social expectations around sex, gender and sexuality, who rock the heteronormative boat *the least*, are also perhaps less organizationally vulnerable” (Bowring & Brewis, 2009, p. 373, emphasis in original). They note that their study stands alone in the Canadian literature regarding “how lesbians and gay men experience and negotiate organizations” (p. 361). As they also note, their sample of 16 participants is limited in size and in its inclusion of only white, able-bodied gay men and lesbian women in ‘professional’ jobs (Bowring & Brewis, 2009, p. 363).

Canadian studies about trans people and employment are equally hard to come by. Some studies that claim to be about lesbian, gay, bisexual, and trans (LGBT) people fail to include any trans people or attend to trans-specific experiences, which are often different (though sometimes overlapping) from those of lesbian, gay, and bisexual people. The Angus Reid survey quoted above is an example of this kind of misrepresentation. The executive summary of the survey refers to “members of the lesbian, gay, bisexual, and transgendered community” throughout the document, but only gay, lesbian, and bisexual Canadians were surveyed¹⁹ (Angus Reid Public Opinion, 2011). While it is possible that some of the gay, lesbian, and bisexual people surveyed are

¹⁹Notably, the detailed results refer only to gays and lesbians and do not specifically mention bisexuals.

also trans, there is no mention of whether or not this is the case and no mention of any trans-specific issues.

The community-based research project Trans PULSE is the only Canadian study to document the conditions contributing to the social exclusion of trans people pertaining to employment (amongst other issues). Trans PULSE surveyed 433 trans people living, working, or receiving healthcare in Ontario in 2009 and 2010. This study found that 71% of trans people have some postsecondary education, but “about half make \$15,000 a year or less” (Bauer et al., 2011, p. 1). Trans people face “unhealthy and unsafe working conditions” due to “the lack of trans-positive attitudes as well as trans-inclusive policies within workplaces” (Bauer et al., 2011, p. 2). Specific challenges include providing references and credentials with current name and gender, coworker and employer acceptance, obtaining and maintaining employment, and decisions about disclosure of trans identity (Bauer et al., p. 2). This is comparable to data from the American National Transgender Discrimination Survey which reports that transgender people are twice as likely to be unemployed than the general population, “with rates for people of color up to four times the national unemployment rate” and that 90% experienced discrimination at work or avoided disclosing trans identity in an effort to avoid harassment (Grant et al., 2011, p. 3). Further, 47% reported an “adverse job outcome” which included “being fired, not hired, or denied a promotion because of being transgender or gender non-conforming” (Grant et al., 2011, p. 3).

As the National Transgender Discrimination Survey shows, race and racism are highly relevant to issues of employment. However, none of the Canadian studies reviewed thus far specifically account for race and racism in the Canadian labour force.

For example, what would analyses of income disparities and other forms of homophobic and transphobic discrimination look like if race was included as a variable? As Galabuzi (2006) argues,

From early European attempts to take control of the land, resources, and trade from the First Nations, which involved restricting their economic participation, to the selective importation of African American, Asian, and Caribbean labour, and the more recent casualization of immigrant labour, race has been and continues to be a major factor in determining access to economic opportunity in Canada (p. 7).

Further, neoliberal restructuring has resulted in the intensification of the racialization of poverty (Galabuzi, 2006, p. 12). More specifically, systemic racism in the labour force is evidenced by the “income gap, the gap in employment levels, overrepresentation in low-paid occupations, under-representation in high-income occupations and sectors, and disproportionate exposure to precarious work” experienced by racialized groups (Galabuzi, 2006, p. 18). Racialized income disparities and differential poverty rates have also been documented by other Canadian scholars (Das Gupta, 2007; Jackson 2002; Khosla, 2008; Ornstein, 2000).

Das Gupta (2007) argues that systemic racism in Canadian workplaces is evidenced through “word-of-mouth hiring, differential treatment at the screening or pre-screening stages, biased interview processes, and the use of vague and subjective criteria in hiring, performance appraisals, and promotions” (Das Gupta, 2007, p. 181). Likewise, another study of racist discrimination in the Canadian workforce shows that racialized people experience racism through various means, such as “a chilly or hostile climate, by limiting access to information or participation in work-related social interaction, or by

introducing bias into decision-making regarding performance appraisal, promotion, developmental activities, job assignment, compensation or other areas” (Agocs & Jain, 2001, p. 5).

There is also evidence that these phenomena are gendered, in that racialized women are relegated to certain low paying sectors such as the “lower ranks of healthcare sector, the textile and garment industry, the service sector and clerical ghettos” (Galabuzi, 2006, p. 8). Likewise, Das Gupta (2007) notes that people of colour generally and women of colour especially are segregated in “low-end jobs in processing and manufacturing, sales and service, and in industries such as clothing and textiles” (p. 181). Similarly, Khosla’s (2008) study regarding racialized women in Toronto found that this group is disproportionately in “manual or non-manual low-skill occupations” (p. 224).

At best, this summary provides a fragmented outline of the bigger picture in terms of employment and the workplace for LGBTQ people who experience mental distress. Clearly, more research is needed in this area, particularly those that consider the intersectional impact of racism, homophobia, transphobia, and sanism. However, this limited information does suggest that LGBTQ people who experience mental distress face significant obstacles obtaining and maintaining employment as well as marginalization and oppression in the workplace, despite the existence of anti-discrimination policies. The interviewees discussed several of these barriers, and provided accounts of some of their workplace experiences, both positive and negative. It is important to note that most of the participants in my study were employed (30 of 37) and as such are not representative of those most affected by oppressive forces that exclude many people who experience mental distress from the workforce. Many also

reported that they had jobs that worked for them or were able to manage workplace dynamics without too much trouble. However, when asked to elaborate about their work lives, the interviewees' stories about past and present workplace experiences revealed various struggles associated with oppression in the workforce, resonating with what is suggested by the scant statistics presented above.

The overarching theme that emerged from the employment related data centered on the processes of disclosure about mental health-related information, sexuality, and gender identity at work and the effects and consequences of such disclosures. As identities, behaviours, and experiences that sometimes require disclosure as opposed to being self-evident, mental distress and some non-normative sexualities and gender identities can raise issues specific to 'invisible' identities. Perhaps for these reasons, the concept of invisibility is taken up in both disability studies and the literature regarding 'sexual orientation' in the workplace. Indeed, analogies are often made between invisible disabilities and sexuality, likening them to one another on the basis of their supposed invisibility. I will problematize these comparisons, while attempting to make use of insights from both bodies of literature. The scholarly work in these areas tends to be singularly focused on either disability or 'sexual orientation' there are few that consider the intersectional character of identity and experience. Additionally, Morrow and Weisser (2012) indicate that there is a lack of intersectional and anti-oppressive "analytic work" that examines "the varied ways in which sanism systematically oppresses people" (p. 31). I analyze the specific experiences created by the intersections of homophobia, transphobia, racism, and sanism.

Mental distress: An invisible disability?

Within the last decade, there have been calls for disability studies to become more inclusive of ‘invisible,’ ‘nonvisible,’ or ‘hidden’ disabilities. Scholars have pointed to the relentless focus on the ways in which identity is constructed through the interpretation of visible bodily markers and the gaze that ‘others’ and marginalizes. Samuels (2003) argues that this focus on visibility has restricted our very understanding of what disability is, marginalizing invisible disabilities and perpetuating visibility as a central organizing tenet for understanding identity, experience, and social recognition (p. 248).

Invisibility is thus becoming an important concept for theorizing identity and experience in disability studies, expanding the boundaries of disability discourse. Disability studies scholars have begun to consider the difficulties faced by those who have disabilities that are not always readily apparent, including struggles with social recognition, access to accommodations, decisions regarding disclosure, and problems in being considered ‘authentically’ disabled by self and others (Caldwell, 2010; Kooistra, 2008; Lingsom, 2008; Samuels, 2003; Tierney, 2002; Valeras, 2010).

Analyses of invisible disabilities are helpful for understanding mental distress. The prevailing assumption governing everyday interactions is that visual cues tell the ‘truth’ about the body and that disability can therefore always be seen (Lingsom, 2008; Samuels, 2003; Kooistra, 2008). As Robinson (1994) claims, “the visible is never easily or simply a guarantor of truth,” yet the assumption that identity and experience can be assessed by looking persists (p. 719). Mental distress is no exception to this; given that it is not always easily ‘readable’ off the body, participants in my study were commonly assumed not to have experienced mental distress.

I therefore position mental distress as ‘invisible,’ though I do not employ this term in a strictly dichotomous sense. ‘Visible’ and ‘invisible’ are not mutually exclusive or discrete categories; whether or not any identity or experience is visible depends on many factors, including context, circumstance, audience, and interpretation. As Valeras (2010) argues about the visibility of disability, it can vary according to “symptomology, medication, time of day, clothing, or activity requirements.” This insight is applicable to mental distress. Many participants indicated that while their mental distress was for the most part not readily apparent to others, there were circumstances when it was. For example, Viki, a racialized, queer, gender-fluid woman, said the following about the visibility of what she called her “chronic mental health problems”:

I do have scars that become visible often..., so it’s almost like I’m already wearing it in a certain way. I don’t want to wear it any more..., like just scars from cutting. I have a hard time on subways, holding onto poles, because I prefer not to wear sleeves. I tend to roll them up.

Viki told me that she experienced judgment and stigma based on her scars and felt that she ‘wore’ her mental distress whether she wanted to or not. Mental distress was ‘readable’ from the scars on her body that were sometimes visible, depending on her clothing and activity.

Mental distress can also be ‘visible’ through behaviour. Mary, a racialized, queer, cisgender woman who works for the government, explained that her coworkers question her based on her mood:

There have been times that I’ve shown my mood a little bit and I am questioned up and down about it because, you know, there must be something wrong. If I’ve

had a quieter day, then I come back, people make comments like, ‘oh, you know, glad to see you’re in a better mood today’ kind of thing. So that’s tough. I think there’s a spectrum for me that’s really low, neutral, and very high. And I think that if I’m just neutral then I get questioned as well because people have seen me at that point and they wonder. And people take it personally.

As Mary indicates, her mental state fluctuates and changes over time and becomes visible to her coworkers when her mood is noticeable to others. Derek, a racialized, queer, genderqueer person, explained that he would “fail at anything paid labour related” and “some volunteer positions as well” because “it seems like if you do not act in a very normative manner, they do not want you.” When I asked him for an example, he told me the following story about a job interview to be rehired for a seasonal job on campus:

One of my problems I recognize I have to work on is I’m incredibly open and honest to the point where it’s not a good thing. So one of the [interview] questions was like, be critical of the practice of frosh [new university students]. I told them exactly what I was thinking. And apparently that wasn’t a good thing, because their faces were, I assumed that was an expression of dislike or shock or something along those lines. Unpleasant, negative.

Derek explained that his response to this question was a critique of specific examples of sexist and homophobic behaviours he had witnessed amongst his former coworkers when he was working at this job the year before. He was not rehired for the position and he believed that both the content of his answer and his way of communicating it were seen as inappropriate and non-normative. This exemplifies that non-normative behaviour can result in being deemed ‘crazy’ and that part of acting ‘normal’ in some contexts is to

adhere to the status quo. Further, it is not incidental that both Mary and Derek are people of colour. It is possible that some behaviour is more likely to be deemed non-normative when displayed by racialized people rather than by white people who may sometimes be assumed to simply be ‘eccentric.’

Mental distress is thus not always strictly invisible or visible. However, for most participants, mental distress was often not readily apparent through visual signifiers and they were therefore often assumed not to have experienced mental distress. For example, Mike, a white, omnisexual trans man, described the relationship between mental distress and visibility in the following way:

I think it’s more of an invisible disability because it’s not as obvious as a physical disability. If you’re in a wheelchair or something like that, then you automatically read someone as disabled. I mean, yeah, I think for the most part I pass as not being disabled because it is my brain, you can’t really see that. But I don’t think it’s any less of a disability even though it is mostly invisible.

Mike draws attention to the importance of what can be seen in defining who is disabled in daily interaction. For Mike, like most participants, mental distress was often invisible, though mental states fluctuate and change over time. As will be discussed more below, this often meant that there were decisions to be made about ‘coming out’ or disclosing mental distress in the workplace.

The ‘invisibility’ of sexuality and gender identity

The concept of invisibility has also been applied to sexuality. Some scholars position queerness as an invisible difference and as analogous to some ‘invisible’ disabilities such as chronic illness and ‘mental illness’ (Beatty & Kirby 2006; Swain &

Cameron, 1999; Ragins & Singh, 2007). For example, Beatty and Kirby (2006) differentiate “sexual orientation” from visible “differences such as gender, race, and age” and liken it to invisible differences such as “mental and chronic illness and invisible disabilities” (p. 29). Such analogies are often extended to processes of disclosure. Swain and Cameron (1999) claim there is a “coming out process” in the workplace for queer people and those with invisible disabilities that “has no real equivalent in gender and race categorizations” (p. 76).

Such comparisons make faulty assumptions about the in/visibility of sexuality, gender, and race. For example, gender expression plays a role in making some sexualities ‘invisible’ and others ‘visible.’ The participants in my study who were perceived as gender normative were often ‘invisibly queer.’ For example, Bettie, a white, queer, cisgender woman, described being seen as heterosexual in her government workplace in Winnipeg based on her feminine gender expression:

Once I was like, ‘actually I’m a big homo.’ [People at work] were like, ‘oh okay.’ It wasn’t a big thing, but there’s an assumption that I’m straight for sure. Because I’m femme..., I get to be invisible.... I’m more screwed by heterosexism than homophobia.

Heterosexist assumptions that equate female femininity with heterosexuality meant that Bettie was invisible as queer until she informed her coworkers otherwise. Participants who were ‘invisibly’ queer did therefore have a ‘choice’ about coming out at work. Being openly queer in the workplace was important to many such participants. Jen, a white, pansexual, cisgender woman who works in social services in Toronto, was often assumed to be heterosexual and found it “stifling” not to be out at work:

I was very clear about that at the outset because I don't necessarily look queer [laughs] to everybody. I made the mistake of not being out at my previous job.... I didn't feel comfortable with the people I was working with, being out to them because, you know, the odd comment had been made or whatever and I felt really stifled by that. So from the get go at this job I decided I wasn't going to do that and whoever had a problem would have a problem and whoever didn't, you know, wouldn't.

However, the assumptions embedded in analogies that position sexuality as invisible and gender and race as visible are problematic. Queer identities are often ascribed to those who are genderqueer or gender non-normative because of widely held assumptions about the connections between genderqueerness and queerness. Despite the widespread nature of heterosexism, these assumptions about the connections between gender identity and sexuality mean that for some queerness or 'sexual orientation' is not always invisible.

For example, Michelle, a white, queer, cisgender woman who was unemployed in Toronto, said about her past experiences working in retail, "I feel like I usually don't have to come out, I'm pretty much read as visibly gay most of the time, so people just know. So I haven't really had a coming out type of talk to anyone that I've worked with." Smith, a white, queer, trans man who works in the service industry in Toronto, discussed being "visibly queer" at work based on appearance: "I'm fairly visibly queer and so I think that was something that was pretty upfront when I was interviewed. No one was like, 'oh look, it's a straight lady'" [both laugh]. Participants like Smith and Michele who were read as a gender non-normative were usually assumed to be queer, often making coming out unnecessary. As this demonstrates, queer sexuality is not always invisible.

This is also something that changes over time given changes in participants' sexualities and gender presentations. For example, Smith had recently begun medical transition at the time of the interview; it is possible that his experiences in the workplace changed along with his appearance.

It is also important to note that the norms that govern whether or not someone 'looks queer' are racialized. As Laila, a racialized, queer, cisgender woman who worked in Toronto in an academic workplace, told me, assumptions are often made about her sexuality based on her gender expression and her race:

Everyone assumes that I'm straight. It's always been the case. Even if I tell somebody that I'm queer, they'll forget the next day. It's been such a common experience for me.... A lot of it probably has to do with the fact that I'm femme and I'm brown. If I looked to them like I was queer, so far as dressing a certain way, if my hair was cropped, I think that they would make different assumptions about me. If I fit into such a particular mold for them, as brown woman with long hair, dressing more femmey, they're going to make that assumption of me being straight.

As Laila's experiences indicates, the norms that govern how sexuality is 'read' off the body are racialized. Further, the assumption that race itself is always visible and never requires disclosure is based on an essentialist view of race that does not account for the complicated nature of racialization. As Somerville (2000) contends, "one's racial identity is contingent on one's cultural and historical location" and is not always "self-evident and visible" (p. 7).

Likewise, assumptions that gender is always visibly ‘obvious’ does not take in to account genderqueer and trans people. Genderqueer people are often perceived as various genders, depending on the context. Derek, a racialized, queer, genderqueer student in Toronto, described this as follows:

Gender wise, it’s complicated. Genderqueer is the closest I’ll get. I typically will identify not male, not female. Ever since I was a very small child, I was a gender ambiguous child. I would confuse people on the streets. ‘Is that a boy or a girl?’ And people constantly asking me this.... I have confused people.... One day I’ll pass as a butch dyke, the next day I’ll pass as a straight woman, the next day I’ll pass as a trans woman, the next day I’ll be a trans man, a gay boy, a straight guy. I’ve passed off as everything.

Derek, like other genderqueer participants, was not always immediately visible as male or female, and his gender presentation was not static and changed over time.

Trans participants who were not genderqueer and who were consistently assumed to be cisgender men or women were invisible as trans and sometimes also as queer.

Devon, a white, queer, trans man in Toronto who worked in an academic setting, discussed his experiences of invisibility as a trans, queer person:

A lot of my identity has become invisible over time and so I kind of feel like I’m always trading off on one thing or another, no matter what I’m doing. For example when I go down to gay pride, a lot of people assume I’m a gay man and so I either have to accept that and that’s where my queerness is gonna be read. Or if I’m with my partner then what am I, who am I? ...I feel like maybe I could

never really be seen for all the things that I am anymore. And that's just a part of being trans.

As Derek and Devon's stories demonstrate, gender identity and gender presentation change over time and are sometimes invisible. This is also supported by the Trans PULSE data, which shows that some trans people are "visibly identifiable" while others are not (Bauer et al., 2011, p. 1). This means that some trans participants faced decisions about coming out as trans at work. The Trans PULSE study argues that trans people who are assumed to be cisgender "are able to choose when and to whom they disclose information about their identity" while those who are visibly trans "do not have this choice...leaving them vulnerable to harassment and discrimination in the workplace" (Bauer et al., 2011, p. 1). While it is true that some invisibly trans people can 'choose' whether they disclose, this choice is sometimes constrained. As the Trans PULSE data shows, many trans people do not have identification, credentials, and references that reflect their current name and gender, which makes nondisclosure very difficult. Those who do may still have their 'choice' to disclose limited by other factors. For example, Caleb, a white, bisexual, trans man, described a retail job interview in Toronto where he was assumed to be cisgender but felt compelled to disclose that he is trans because it was difficult to answer the interview questions honestly without doing so. He was hired for this job, and on his first day at work he was shocked to discover that his employers had disclosed his gender identity to all of his coworkers. Caleb was angered by this and wondered how the information had been disclosed and what conversations had taken place without his knowledge. As he said:

I would like to know how this conversation came about.... Like, ‘so, you know, this new guy, he sounds really cool. He’s trans’ [both laugh]. If you really think about that, it’s kind of like informing everyone that I have a vagina or something. It just doesn’t, you know, it’s not something that comes up in conversation. ‘This is our new employee. He has a vagina’ [both laugh].

Caleb’s story demonstrates that trans people’s ‘choice’ to disclose is affected by more than their in/visibility and that trans people can be vulnerable to transphobia regardless of whether or not they are initially assumed to be cisgender.

As the interviewees stories demonstrate, scholars who position queer sexuality as invisible and gender identity as visible do not take in to account trans people and the interrelationship between sexuality and gender expression. Sexuality and gender identity are visible according to context, audience, and the interaction between sexuality, gender identity, and race. However, as I have suggested, the ‘invisibility’ of sexuality and gender identity for many participants in some contexts meant that there was a ‘coming out’ process regarding sexuality and/or gender identity for those assumed to be heterosexual and/or cisgender. Even those who had disclosed some information or who had assumptions made about their identities faced ongoing decisions about disclosure. The factors that influence these decisions will be discussed further below.

It is also important to note that disclosure or coming out is never “a static and singular event” (Samuels, 2003, p. 237). This can be heightened for those whose appearance doesn’t ‘remind’ those around them of their identities. However, even those who have come out or who have assumptions made about them have to make ongoing decisions about disclosure. Ragins, Singh & Cornwell (2007) argue that “those who fully

disclose at work still need to disclose to new coworkers, managers, clients or vendors and thus these employees continually face the risk of a negative reaction to disclosure” (p. 1115). As A.P, a racialized, queer, cisgender person, shared about a retail workplace in Toronto:

At my first job...where a lot of people knew me, then they sort of just like forgot, I guess. People kept thinking of me as straight. I sort of had to remind them and I don't really want to do that because it comes off as really annoying.

As this indicates, disclosure can therefore be seen as an ongoing process that requires a series of decisions about when, where, and how much to disclose. Further, sexualities and gender presentations change over time and as such may require ongoing disclosures.

‘It’s personal’: Disclosing ‘private’ information in the workplace

Many participants found that their workplaces were characterized by self and others as ‘public space’ where ‘personal’ information has no place. This imperative to keep certain experiences and information private had an impact on what they felt was appropriate to disclose at work. Many participants believed that experiences of mental distress were considered ‘private’ and therefore an inappropriate topic in the workplace. As Smith, quoted above, said about mental health related information in his Toronto workplace in the service industry: “I think there’s an attitude of that’s not something that you talk about at work. Or that would be something you would talk about with your friends or in therapy and it’s not something that you bring to work.” Similarly, Andrea, a white, queer, cisgender woman, characterized her retail workplace in Winnipeg as a space that is seen as free of “other people’s problems”:

I don't think that people really want to hear about other people's problems [laughs] a lot of the time in the workplace. They're just like, 'you mind your own business and I'll mind my business and I don't want to hear about any of your crap.'

Jaime, a racialized, lesbian, trans person, characterized mental health related information as "really personal" and therefore something she would not discuss at her job in manual labour in Winnipeg. Allison, a Torontonians who identifies as white, queer, and genderqueer, told me about disclosing mental distress at her job in media: "it's not something I would just, you know, out of the blue bring up." Likewise, Barry, a white, gay, cisgender man in Winnipeg, said about his job in a government workplace, "You know, it wouldn't be appropriate to just all of a sudden like yell out, 'I have depression.'"

This was also the case regarding information pertaining to sexuality and gender identity. As Brock, quoted above, said about a retail workplace in Winnipeg:

One of my workplaces was this small...company. I just didn't feel comfortable discussing my sexuality with the owner. Just one of those jobs where they were good to me, but politically we did not mesh. So those things you can't separate as much as people say you can. There is no such thing as a work life and a personal life; they are one and the same thing. The identity doesn't change; it's just your behaviours do.

Brock's comments draw attention to the distinction that is often made between private and public space and the accompanying expectations about what is 'personal' and should be kept private. Another participant, Donovan, a white, queer, gay, cisgender man, said about his academic workplace in Toronto, "I'm not going to write on blackboard that

I'm gay [both laugh]. You know what I mean?" Similarly, Laila replied "Oh hell no" when I asked her if she is out at her academic workplace in Toronto, because she doesn't "talk to people about my personal life." Jaime, quoted above, told me that there is "no space" for discussions of sexuality at work in her manual labour job in Manitoba:

On the farm it was like, ugh. I don't need to talk about my sexual orientation around here at all. And that was just because there's just not any room for this, even though there's this great amount of space, prairie everywhere [both laugh]
I'm like, 'no.'

The extent to which information about sexuality and gender identity are considered 'personal' should not be underestimated. Devon, quoted above, shared the following story about transitioning on the job in manual labour:

I transitioned on the job.... It was really weird to do that because my boss never knew and I just started to slowly but surely changing significantly [both laugh].... There's a certain point at which all the customers thought I was 'he' and called me 'he' and my boss, I think it was a process of realization for him. At first he thought people were hurting my feelings, and then he realized that it was intentional. So it was this funny thing, like how you could think somebody doesn't know they look like a man is bizarre [both laugh]. I've dressed myself since I was five, I know what I'm going for.... And so I think he came to realize that maybe that was okay with me and we didn't talk about our personal lives or anything too much.

Despite the fact that Devon's transition was visible to his employer, this was still seen as part of his personal life and was not discussed in the workplace.

Even participants who were ‘out’ at work still felt an imperative to censor what they said in the workplace. As Bowleg, Brooks, and Ritz (2008) argue, workers who are out still have to “make strategic decisions about when and how to disclose their sexual orientation to minimize negative reactions” (pp. 77-78). This was true for some participants. For example, Barb, a white, lesbian, cisgender woman, was “uncomfortable” at her manual labour job in Winnipeg because she could see that “there was a real sense of discomfort” when she mentioned weekend plans with her partner. This caused her to refrain from discussing many parts of her life with some coworkers. As she said:

But the day to day, you know, going for lunch with somebody or taking a break and chatting about stuff.... I’m a person who’s pretty comfortable sharing things and so to sit there and not be able to talk freely about what I did last night or what I’m going to or whatever makes me very uncomfortable.

This issue was exacerbated for Barb as a lesbian woman working in a male-dominated profession. She explained that her boss was very uncomfortable with “a strong female” who wore boots and is “a little rough around the edges.” This made it even more difficult for Barb to discuss anything pertaining to being a lesbian. Another participant, Smith, quoted above, told me that he is careful about what information he shares at his job in the service industry in Toronto:

I think that sometimes I tend to censor the things that go on in my life, even in just the way of people being like, ‘what did you do last weekend?’ I’ll think about the things that I’ll talk about. I think that I kind of like pre-empt that by holding back on certain things.

As this demonstrates, when queer sexuality isn't actively kept invisible as it is expected to be, it becomes hyper-visible; simply mentioning mundane details about a partner or weekend plans is seen as inappropriate, yet the pervasiveness of heterosexuality in the workplace goes unnoticed.

One popular solution to counter the imperative to keep such information private is to 'come out' in the interest of increasing visibility and acceptance for marginalized groups. For example, Beatty and Kirby (2006) propose that visibility holds "the key to social and cultural acceptance" and that gays and lesbians who come out can change the world "one encounter at a time" (p. 40). While recognizing that there are "short term difficulties" that are "risky," they support the idea behind National Coming Out Day, an international day when LGBTQ people are encouraged to 'come out of the closet' and disclose their sexualities and gender identities (Beatty & Kirby, 2006, p.40). This perspective replicates the aforementioned assumption that LGBTQ people are always invisible and it minimizes the structural barriers and violence that prevent people from disclosing their sexualities and gender identities. It also puts the onus of social change and increasing visibility on LGBTQ people. While the 'one encounter at a time' to changing oppressive attitudes can be powerful, there are larger problems that structure these encounters. These include the widely-held assumption that everyone is a member of the dominant group unless there are immediately visible indications otherwise, the imperative to come out rather than a responsibility not to assume that everybody is heterosexual and cisgender, and the negative consequences of disclosure.

‘It’s irrelevant’: Sexuality, gender identity, race, and mental distress as ‘neutral’

‘Personal’ information about sexuality, gender identity, race, and mental distress is also often portrayed as a neutral social difference that is irrelevant to supposedly objective evaluations of job performance and assumptions about employee’s professional capabilities. However, such information is in fact tightly tied to perceptions of capability. Disclosing LGBTQ identities and relationships in a homophobic and transphobic workplace can be very unsafe and have negative consequences. As Ragins, Singh, and Cornwell (2007) argue, “concealment may be a necessary and adaptive strategy for LGB workers in nonsupportive or hostile work environments” (p. 1108). For example, Barry, quoted above, shared the following experience about working in a homophobic environment in the service industry in Winnipeg:

At my old job they weren’t going to hire this individual because he was gay. That made me that much less comfortable with myself at work. The guy handed in his resume and when he left one of [my coworkers] walks over and says, ‘Don’t hire him, he’s fucking gay. It’s disgusting.’ And then the manager just kind of nodded and tucked it under the till and kept working. At that point there were a couple people who knew [I am gay], so they were like ‘are you okay?’ and I’m like, ‘no. I want to go home.’

It is difficult to imagine that Barry could have disclosed that he is gay to everyone in this workplace or that it would have been safe for him to do so. Barry’s story also indicates the limitations of anti-discrimination protection, which cannot fully address situations like this. Likewise, Aaron, a racialized, gay, cisgender man in Toronto, told me the following story about a homophobic manager in a retail job who assumed he was straight:

The manager of the first store that I worked at used to be a security guard [at a place where] the bathrooms were a big hook-up spot for gay men. So my manager would describe how fun it was to go in and scare the fags and how he missed that job and how it's a lot harder now because he has to be more responsible.

Jen, quoted above, characterized her coworkers in social services in Toronto as “close minded” because “they would make off-hand closed minded comments.” This caused her to think, “Well if you're closed minded about that, then I probably should try my best to appear as normal as possible’. I would never go out of my way to appear different or anything like that when I was there.”

Indeed, the ramifications for disclosing can be many. Participants who did disclose or who were assumed to be LGBTQ often faced offensive comments, hostility, or ostracism at work. Michelle, quoted above, told me that once her coworkers in a Toronto retail workplace realized she is gay, “They don't really know what to say or they don't use appropriate terms. It's not that they're trying to be offensive, but it sometimes comes out that way.” She went on to say that her coworkers “just didn't know how to relate.” Similarly, Andrea, quoted above, told me her coworkers at a retail job in Winnipeg were “both familiar and yet trying to be unfamiliar with you even if you worked in the same department” and that they “weren't as friendly to me as they would have been if they wouldn't have known that I was queer.” Crabitha, a Métis, lesbian, cisgender woman who worked in a corporate workplace in Winnipeg, discussed being taken by surprise by homophobic attitudes [at work] once she had disclosed her sexuality:

I had a boss that I admired very much. He was my mentor and I loved working with him and thought really highly of him. One day I mentioned to him that I

would invite him to my wedding if I ever got married and he said, ‘I wouldn’t go.’

So I thought that was shocking and that hurt quite a bit. But he was honest.

Intersectional oppression also had an impact on whether participants obtained work, were promoted, and retained jobs. As Ragins, Singh, and Cornwell (2007) argue, there are many negative consequences for queer employees. As they state, “Employees who disclosed more reported lower continuance organizational commitment; earned less compensation; and reported less pay satisfaction, more turnover intentions, and fewer opportunities for promotion than those who concealed their sexual identity” (p.1108). Barry, quoted above, discussed differential treatment in promotion decisions in his government workplace in Winnipeg: “There’s two of us there, both of us are fit and qualified, I’ve been with the company longer, and they pick the other individual and he’s a heterosexual male. I’m gay, it’s very known, and then they go with that person.”

Participants also reported difficulty obtaining work. Sonja, a Métis, bi-queer, cisgender woman, described difficulties getting bartending work in Winnipeg due to gendered and racialized beauty standards:

I have experienced difficulty getting jobs in bars as a bartender based on my gender presentation especially. I think a lot of bars want the boobilicious long-haired girl who wears make-up. I’m definitely not presenting my gender that way. I’m definitely female but I’m not female enough, maybe, or feminine [laughs]. So in that industry I definitely have a concern with getting work. And I eventually just wrote it off. I really like bartending, I feel like it’s something I could do for many, many years. And just no outlet for it. Because apparently people won’t

come to the bar if there's no hot blonde behind the counter. I thought it was alcohol that got people into the bars, you know [both laugh].

Similarly, Andrea said she had difficulty getting retail jobs in Winnipeg based on attitudes regarding her gender presentation. As she said, "People take one look at my short hair and hairy legs and they're like, 'yeah I don't think you'd be suitable for this work environment.'"

This was also a concern for trans participants. Brayden, a racialized, gay, trans man, quit his job in manual labour in Winnipeg because of transphobic discrimination:

As soon as they found out I was transgender, they didn't like it.... There was two people that were fine with it, but the rest, everybody was just like, 'Don't touch me you've got a disease' type thing.... That's why I quit, because of that.

Brayden's coworkers and employers made his workplace environment so hostile that he felt like he needed to quit his job. Likewise, Josh, an Indigenous, heterosexual, trans man, was fired from his manual labour job in Winnipeg for being gendered as male by the customers:

My boss found out and a few of the other people because a lot of the [customers], I got along with them and they'd joke around with me, and they all thought I was a guy. The boss found something wrong with it. He was a bible thumper and I went into work one day and he just told me, 'You're fired.' 'For what?' They claimed things went missing.

Brayden and Josh highlighted the effects of transphobia in these interactions, but it is not incidental that they are both racialized and working in manual labour,

presumably in non-unionized workplaces.²⁰ As outlined above, racialized people face systemic racism and discrimination in the Canadian labour market and often work in precarious conditions

Indeed, many of the racialized participants discussed experiences of racism at work in many types of jobs. Laila, quoted above, described how racism is prevalent in her unionized academic workplace in Toronto, including white professors who don't recognize racialized graduate students, despite working closely with them in various contexts, classes that "don't talk about race or make it like a special topic of the week," fellow graduate students who are "super racist and exclusionary," an admissions process that lets in "mostly white students," student committees dominated by white students "who then take positions in other committees...and maintain power in that way," and a lack of support for racialized teaching assistants who have students in their classrooms who are "racist in really hurtful and blatant ways." For Laila, this meant that she felt isolated at work:

I don't hang around much, that's one of the things. A lot of people will go and hang out in the lounge space or go to the committee meetings or whatever, and I don't do that. I just don't feel like I want to be in that space. I don't feel comfortable in that space. I feel in some ways that my presence is being challenged.... I feel sometimes a bit isolated in the program for those reasons.

Mary, a racialized, queer, cisgender woman, described a job in Toronto where she felt "categorized" as a black woman and expected to do extra duties not included in her government job description:

²⁰ I did not ask participants if their workplaces are unionized. However, based on Brayden and Josh's descriptions of their workplace conditions, I believe they were not unionized.

So, and race, I wouldn't say like discriminated against but definitely sort of categorized, because my position can be relatively administrative so there are some older white males that see this black woman as someone who has to do all these things and there's a lot of things that aren't really my job because it's not technically administrative. And I've had someone say to me, he asked me if I could do something and I actually didn't know how to do it and he said, 'Isn't that your job' and so [both laugh] I thought, 'Well, not really. I mean I would help you if I could [both laugh]. I just don't know how to do this.'

Aaron, quoted above, described blatant discrimination based on race in his retail job in Toronto, where his manager "joked around that they only gave me the job because I was black and there were too many people working at that store who were white or not racialized enough." Similarly, Travis, a Métis, queer, cisgender man, was told by a manager in social services that "the only reason" he was hired was his race. He also described more insidious problems in another workplace where he was one of few Aboriginal service providers in an agency that mainly served Aboriginal clients:

I would almost call this racism. It's just weird because all the clients are Aboriginal, or the majority of them, but very few practitioners or service providers are. Some of those practitioners and some of those folks don't believe in the fact that Aboriginal folks need to be providing services for Aboriginal people or services from a cultural perspective.

The prevalence of racism also means that racialized people who experience mental distress are facing increased scrutiny and discriminatory evaluation of their job

performance. As Marcus, a racialized, queer, trans man in Toronto, told me about work in the social services,

If I am not doing my work it's much more noticeable than my white counterparts who aren't doing work and who are walking around and talking – and that's fine – and if I do the same thing it's, 'What are you doing, you suck.' But if I'm next to the [white] person who's not doing the work, then it becomes apparent that that person is not doing work, but it's not apparent unless that contrast is there. That made me realize, it looks like the person of colour drops the ball – and it takes that much to bring it back up – whereas I feel like there's a lot more forgiveness with [white] folks.

Marcus describes the double standard for racialized people in the workplace, who are evaluated more strictly than white people. One of the most common fears amongst participants was that the disclosure of mental distress would mean being seen as incompetent in the workplace. For racialized participants facing the racist double standard described by Marcus, there was an increased risk associated with disclosing information about mental health or mental distress. This resonates with a study by Ragins, Cornwell, and Miller (2003), who find that “gay people of color” are less likely to disclose “sexual orientation” at work than white gay people. They surmise that disclosing may be riskier for queer racialized people, because as a “numerical minority” they are already “under a microscope at work because of their race” and coming out may “add fuel to the discriminatory fire” (Ragins, Singh, and Miller, 2003, p. 67). Though these authors are referring to the disclosure of sexuality, it is reasonable to speculate that

queer racialized people may be even more reluctant to disclose mental health related information as well.

Participant narratives revealed that mental health related information was also not a ‘neutral’ or irrelevant factor in the workforce. Participants carefully considered whether or not to disclose mental health information. For some, this process began with job searching. Whether or not to disclose mental distress to potential employers was a high stakes decision that had an impact on obtaining work. David, a white, Jewish, gay, cisgender man who worked for the government in Winnipeg, told me that he feels strongly about disclosing mental health information when job searching because he is not able to work without access to disability accommodations:

It scares the shit out of me, if I have to look for another job, oh my God. What am I gonna do? When do you disclose? This is a whole ball game for me now. I don’t know what I’ll do. But I sure as hell know that I’ll say I have a disability and here are my limitations. That I will always say. And if you can’t help me out with that, I can’t help you out, obviously.

David feared that disclosing mental health information would compromise his ability to obtain work, but knew that working in an inaccessible environment would compromise his health. Angela, a white, gay, cisgender woman who worked in advertising, also described struggles with disclosure while job searching in Winnipeg, explaining that her mental health-related absence from work created a gap on her resume that was difficult to explain:

The first time I got sick it absolutely destroyed my life in a lot of ways. I was at the peak of my career and then a lot of things happened and then I could not get

back to work for another three years. And then you have to deal with a whole gap on your resume. I was going through a lot of interviews and the biggest thing was, ‘What is that gap?’ I’m not one to lie and sugar coat things, but I was just like, ‘Oh I had this health issue.’ Luckily [my current workplace] didn’t ask me, ‘Why haven’t you been working? What have you been doing with this time off?’ But it does affect me maintaining employment because what if I get sick again?

Similarly, Barb, quoted above, was unsure how to explain her absence from the workforce in Winnipeg and worried that her experiences of mental distress had already been disclosed by others, affecting her ability to obtain work:

Now that I’m feeling a little bit better, the pressure’s on to figure out what I’m going to do with my life now.... What do I tell people if I decide to go someplace else? How do I, without lying, cover up the last two and a half years? ...It’s Winnipeg, you don’t know who knows who.... That’s gonna be a really difficult thing to deal with. I guess I’m not prepared to handle it just yet.

Those who experience mental distress are also at risk of being perceived as incapable of adequate job performance. Indeed, as Lapsley, Waimarie, & Black (2002) argue, the association of mental distress with “unreason, excess, incapacity and unreliability are historically entrenched attitudes in Western societies” (p. 4). This had an impact on whether or not participants felt that they could disclose their experiences of mental distress at work. Michelle, quoted above, said she avoids talking about her mental health in Toronto retail workplaces because she is “afraid of how that would affect your coworkers’ or your boss’s perception of you and your ability. That’s just scary how someone could then think of you as less of an employee. So I’ve never brought that up

with anyone.” Esther, a white, queer, cisgender woman in Winnipeg, told me she is “picky about which workplaces” she discusses her anxiety in, because she fears “being seen as incapable, or unreliable, and unpredictable.” Viki, a Torontonion quoted above, was also “genuinely concerned” that she would be seen as “not a full worker” and a less “desirable employee” if she were to be “honest” about her mental health in her social service job. As Caleb, a Torontonion quoted above, also told me, his capabilities at school were questioned by his graduate supervisor:

It was done in a really kind of back-handed way. Basically I was questioned by a professor and supervisor about whether I was really truly committed to doing this kind of work.... I said, ‘I don’t think that me [working] at this pace means that I’m not dedicated to the work that I’m doing. I’m making decisions in my life that are healthy for me and I will continue to do this at the pace that I need to do it at’...

Whether professors have said this or not, that’s been my fear: that they truly feel that I clearly can’t handle this, or that because of mental illness it renders me not as good as other students in the graduate program.

As Caleb’s comments also suggest, employees are often evaluated using able-bodied standards. The assumption and expectation that everybody is able-bodied is also tightly tied to evaluations of job performance. Participants were often measured against able-bodied standards and the invisible nature of much of the distress they experienced often meant they were facing suspicion and disbelief, something characteristic of the experiences of those with invisible disabilities (Lingsom, 2008). A.P. a Torontonion quoted above, described this as follows:

People don't really get the whole concept of disability in general. It's like, if someone is young and appears healthy, then they don't understand why someone might need a lot of appointments or might not be able to do particular things that they think they should be able to do.

Sonja, quoted above, described the difficulties of being measured against able-bodied standards and the ways in which her symptoms of anxiety were easily dismissed in her government workplace in Winnipeg:

Sometimes I'll say, 'Okay, I've had chest pains for four hours now because of the level of stress. I'm going to have to take a break now.' And I'm afraid people will roll their eyes or be disappointed and talk about how incapable I am of dealing, you know. I do worry about having to express my needs if they're not in line with someone who's not anxious.

Like Sonja, many participants feared that being measured against able-bodied standards would result in negative repercussions and pushed themselves to continue working, often increasing their distress. This common concern led many participants to avoid disclosing mental health information unless absolutely necessary.

Sanism, authenticity and access to accommodations

The need to access workplace accommodations often required participants to disclose mental health information. As suggested by some of the stories above, however, the invisible character of mental distress made it difficult for the participants to be perceived as 'authentically' or 'truly' disabled and therefore entitled to accommodations. People with invisible disabilities are often thought to be making fraudulent claims to a disabled identity and are seen as less legitimate candidates for disability accommodations

(Lingsom, 2008; Valeras, 2010). Indeed, Manning and White (1995) found that “eighty-two percent of employers would usually believe someone being off sick for a physical illness, compared to only 63% of employers believing someone was genuinely ill with a psychological illness” (p. 542).

Struggles with being perceived as ‘authentically’ disabled are particularly relevant to mental distress as an invisible identity and experience because of the prevalence of sanist ideologies that position mental distress as a form of personal weakness that can be easily overcome if one would simply ‘buckle down and pull up one’s socks.’ Many participants had encountered this kind of attitude, which made it difficult to be seen as ‘authentically’ disabled and in need of accommodations. Barry, quoted above, described the difficulties of having depression taken seriously in the workplace. He told me that if he were to tell his employers at his government job in Winnipeg, “I’m really depressed, I really need to talk to someone,” he would be told to “suck it up and get back to work.” Similarly, Betty, a white, cisgender, queer woman, found that having a panic attack would not be seen as a legitimate reason to miss work at her government job in Winnipeg:

At my most recent job, I would never have called in crazy to work. Ever. I’m not sure if that would be seen as a legitimate reason to take a day off work, even though it’s way more legitimate than that I have a cold, because I’m sick. If you have an hour long panic attack where your heart’s beating way faster than it should be beating, you need to take a break after that.

As middle-class government employees, Barry and Bettie were able to navigate this problem by using sick days without disclosing their experiences of mental distress.

Low-income participants experienced more serious ramifications. Lisa, a white, Portuguese, French-Canadian, lesbian, queer person, expressed frustration about not being able to access necessary accommodations in retail jobs in Winnipeg because mental health was not seen as an adequate reason. This resulted in Lisa losing several jobs because she was refused time off to attend mental health related appointments. She also described how mental and physical disabilities are treated differently at one of the retail positions she had to quit:

If I have an appointment because I have dialysis every week, work will actually let me go. If I have an appointment for therapy, which is my well-being, which means that I could go to work every day, which is just as important as dialysis, work will not let me go. It is not okay to miss work for a therapy appointment but it is okay to miss work for dialysis.

Lisa described a common concern amongst participants: mental health concerns are perceived as ‘no big deal’ and participants were seen as simply slacking off and making unnecessary or fraudulent requests for accommodations. Similarly, Raven, a Métis, trans, genderqueer person, asked a doctor in Winnipeg to help him receive governmental disability benefits based on his experiences of severe anxiety and panic attacks:

I told him I had generalized anxiety and he was like, ‘oh I have anxiety, and I work.’ He was just a complete asshole, it was awful. Amongst other things he’s like, ‘it’s not like you’re flying a plane or something.’ I left out of there in tears. I was just like, ‘oh my god. Like what the fuck am I going to do, I have no fucking money and nobody’s going to help me and this is fucked up.’

Further, Raven explained that as an Indigenous, poor, genderqueer, young person, he often has trouble with doctors minimizing his experiences and is sometimes perceived to be ‘drug-seeking.’ The underlying ideology that mental distress does not constitute legitimate grounds for accommodation governed all of the interactions described above, but the impact was softened for those who worked in more class-privileged environments and those who experience white privilege.

Unfortunately, when mental distress is ‘taken seriously,’ it is often associated with violence and lack of control. Sanist ideologies position those who experience mental distress as dangerous, threatening, volatile, and even murderous (Beresford 2002; Holland, 2012; Steadman et al.; Tierney, 2002). Participants were concerned that these kinds of commonly held oppressive beliefs about ‘mental illness’ would affect their work lives if they were to disclose. Barry told me that he downplays or “glosses over” discussions of depression in the workplace because,

When you say you’re depressed, people kinda get this idea that you were a secret cutter or you were like trying to drown your baby in a bathtub. [They] think of like the worst case scenarios and not the shades of grey that are in the middle.

Barry feared that prevalent stereotypes about ‘mentally ill’ people as violent and murderous would govern his coworkers’ and employer’s perception of him. Notably, in Barry’s example, it is when one’s mental state becomes visible on the body through cutting that it is taken ‘seriously.’ Another participant, Jen, quoted above, told me she hesitates to disclose experiences of mental distress in her social services workplace in Toronto for the following reasons:

There's a perception that if you have mental health, you're deranged and you're gonna fly off the handle, and you're one step away from, you know, going nuts. Or that you have a defect in some way. And I think that with something like social anxiety or depression, it's seen as a character flaw instead of a mental health issue. And that's bad, too, because people say, 'Well why don't you just get over it,' and that's not helpful either.

Similarly, A.P., quoted above, explained the ways in which she is seen as threatening, volatile, and incapable of doing an adequate job in retail positions in Toronto:

Depending on how well I'm hiding it or whatever at that particular workplace, people either see me as a threat, like someone who could suddenly flip out on them for no apparent reasons, or someone who has to be sort of sheltered, like not be allowed to take on too much.

Though none of the racialized participants specifically highlighted the effects of racism in terms of being perceived as threatening, it is important to note that racism plays a role in this dynamic. As Fernando (2010) argues, ideas about who poses a threat are racialized, with black men in particular being positioned as violent or threatening (p. 69). It could therefore be said that sanism interacts with racism in particular ways to position some people of colour who experience mental distress as particularly threatening.

As the participants' narratives show, many experienced a double bind; being perceived as 'not crazy enough' and complaining about nothing or being perceived as 'too crazy' and therefore potentially violent and out of control. Either way, participants were perceived as incapable of adequate job performance. This double bind acted as a

powerful barrier to disclosure, resulting in difficulties with gaining access to necessary workplace accommodations.

This often meant that the participants suffered negative consequences in terms of their health and financial well-being. This was especially true for those who worked in lower income jobs with no benefits or paid sick days. Smith, quoted above, who worked in the service industry in Toronto, described this as follows:

There have definitely been times in my life where I could have benefitted from being able to take time off. That's not really a reality, both within the [service] industry and also in terms of finances. You don't often have any kind of benefits package or there's no such thing as sick days. If you take a day off, then you don't get paid.

Likewise, Rob, a white, French-Canadian, queer, gay, cisgender man who worked in retail in Winnipeg, described making difficult decisions about whether to sacrifice his health or his finances, saying that “there comes a balance of taking care of myself but also being able to provide for myself financially. There are times when I may have made a choice that wasn't in the best interest of my mental health but rather in the best interest of my financial well-being.”

Other participants described quitting their jobs rather than disclosing mental health information. As Michelle, quoted above, told me about her retail jobs:

I've had to quit jobs before because of times in my life where I haven't been able to work. I would just flat out quit instead of saying I need time off for whatever. I guess out of fear or just not feeling comfortable enough to bring that up.

Likewise, A.P. described troubles maintaining work in retail, stating that she was only “able to keep a job for at most a year before it all goes to hell and I have to quit for my own health.” These narratives indicate that there are serious consequences to not being able to access accommodations, including negative effects on health and economic hardship, particularly for those who held jobs with no benefits and paid sick days.

Making the workplace more accessible

Some participants had jobs that worked well for them and recounted positive experiences in the workplace. Stacey, a white, queer, person who works in the service industry in Winnipeg, discussed the importance of flexibility so she can follow the natural “swing” of her productivity. She described being able to be absent from work for two weeks when she’s “at ten percent” and then “going hard for two” weeks when she feels like she’s “at three hundred percent.”

When I start to be creative again and feel that swing going up I can just jump right into the up and go, and push it and use it to my advantage. Then when I start to come down, realizing that I need some time off. And it’s okay because there’s that understanding and there’s a dialogue with where I work. And it’s like everything’s getting done and so it doesn’t really matter.

The flexibility of Stacey’s job meant that she could work in accordance with how she was feeling while still accomplishing all of her work duties. Esther, quoted above, also described positive workplaces experiences at an organization in Winnipeg that provided small amounts of money to employees for self-care, to be spent as they wished. This workplace also made “room...for discussing where you were at with the supervisors” and treated all employees the same “regardless of how many hours per week they worked.”

Travis, quoted above, described a positive work environment in the social services in Winnipeg where managers would not tolerate homophobic commentary and placed the responsibility of addressing it on all employees:

There were actually some really good staff that would put an end to it [homophobic jokes]. When I first started..., the manager...pulled all the staff together one day and said, 'I've been hearing...really derogatory comments, a lot of homophobia.' She's like, 'You guys need to address that when it happens.' ...She was essentially like, 'You guys better be on top of this, I'm not letting it happen.'

The explicit sanction against homophobia made Travis feel more supported in the workplace. Raven, a Winnipegger quoted above, also characterized his work environment in social services as "supportive" and "comfortable," largely due to the presence of coworkers and managers who were racialized, queer, and trans and who had personal experience of "mental health issues" and addictions.

I'm like, 'Okay, this is awesome, I feel comfortable here.' And I think there's maybe only two white people..., which is also really good.... Yeah, it's definitely supportive for that. And you know, everybody's queer and there's several trans folks and we all have mental health issues and we all have addictions or have had addiction issues, so it's really good in that way.

Raven emphasized the ways in which having others at work with similar identities and experiences created a positive environment. Indeed, it is presumably much easier to be out and comfortable when one is not isolated or tokenized in the workplace.

Some participants also shared ideas about the characteristics of an ideal workplace. Allison, who worked in social services in Toronto, expressed the desire for more understanding and normalizing of mental distress, where “‘diagnoses’ aren’t seen as labels and that they might just be things that people either deal with on a daily basis or things that somebody might be going through.” She went on to emphasize the importance of employers who are invested in “putting people over making a profit” and encouraging employees to “talk candidly” about mental health and respond with “understanding.” Similarly, Travis, who worked in social services in Winnipeg, told me that an ideal workplace environment would encourage discussions of mental health and self care:

I think that that [an ideal workplace] would look like a place where folks actually talk about mental health stuff, but also talk about self-care and a holistic approach. I think that would go a long way. Especially the self-care part, even simple stuff like how do you deal with stress? If you’re not dealing with stress, well then what builds up, right?

Based on participants’ accounts of negative, positive, and ideal workplace environments, it is clear that there are specific conditions that increase workplace accessibility for many LGBTQ people who experience mental distress. They are as follows:

- flexibility with start/end time of workday and the hours when work is performed
- being able to leave work when feeling distress without being penalized
- time off for mental health related appointments
- being able to take paid sick days from work

- up front information about what accommodations and services are available in the workplace and encouragement to make use of them for all workers, regardless of disability status
- employers and managers who are approachable and de-escalate stress, rather than applying pressure
- employers and managers who are aware and knowledgeable about mental distress and who work *with* employees to achieve maximum job performance, rather than expecting everyone to live up to able-bodied standards
- employers and managers who encourage an open dialogue and positive relationship with all workers
- anti-oppressive workplace climate: not only regarding mental health and disability, but also about race, sexuality, gender identity, and class
- other queer, trans, racialized people who experience mental distress as coworkers and managers

Most of these recommendations are consistent with the literature regarding accommodations and improved conditions for those who experience mental distress in the workplace. A Canadian study of 36 “consumers of mental health services” found that optimal conditions included a “friendly, respectful, communicative work environment with a culture of flexibility and inclusion...a relaxed, easy-going environment with a minimum of competition” (Kirsch, 2006, p. 27). This study also found that positive coworker relations and supervisors who had “qualities such as willingness to provide

feedback and to communicate openly, fairness, commitment, supportiveness, a sense of humour, and an ability to convey the worth of the employee” were crucial factors influencing job satisfaction and job retention (Kirsch, 2006, p. 28). Similarly, Peters & Brown (2009) summarize their recommendations and those of other scholars as “flexible work scheduling, increased supervision, working from home, being able to bank overtime hours for use when ill, self-paced work, longer or more frequent break periods, time-off for counselling, and private offices or enclosed spaces” (p. 41)²¹. These recommendations are similar to my own, with the main addition being an emphasis on anti-oppressive workplace climate in terms of all forms of oppression and marginalization, not just sanism. It is also important to note that making many of these accommodations available to all workers regardless of disability status decreases the pressure on those who experience mental distress to disclose mental health information they may not be comfortable discussing.

However, these recommendations mostly address issues pertaining to those who are already employed. Given the high rates of poverty and unemployment for people who experience mental distress, action must also be taken to support those who have more difficulty attaining and maintaining employment. As Morrow et al (2009) argue, the “divide between employment and welfare” that typifies neoliberal forms of governance does a disservice to those who experience mental distress (p. 671). They suggest that models that combine employment with social support are far more effective and in line with “recovery-oriented values” (p. 666). For example, social enterprise models and community based supported employment offer paid work alongside “social supports such as on-site job coaching, personal and life skills counselling and referrals to others

²¹ Ellison & Russinova, 1999; Fabian & Waterworth, 1993; MacDonald-Wilson et al, 2002; Mancuso, 1990.

services” amongst others (p.667). Models such as these can go a long way toward more equitable inclusion of people who experience mental distress in the workforce.

In this chapter I employed insights from scholarly work about invisible identities in order to analyze the work lives of the participants in my study. I have shown that mental distress, sexuality, gender identity, and race cannot be defined as personal, private, and neutral social differences that have no impact on perceptions of professional capabilities. LGBTQ people who experience mental distress face powerful barriers to disclosing mental distress, sexuality, and gender identity related information at work, which affects their financial and mental well-being in many ways. LGBTQ people who experience mental distress face specific challenges in the workplace, yet their struggles also resonate with what has been documented about those with other forms of invisible disabilities and the literature about disclosing ‘sexual orientation’ in the workplace. My analysis contributes to scholarly conversations troubling one of the central tropes of disability studies, that of visibility, as well as the emerging field of mad studies. While it is important for mad studies to become established as a field in its own right, analyses of mental distress can continue to expand the confines of disability studies, enhancing understandings of concepts such as invisible disabilities.

Conclusion

Gender and sexual dissidence have a longstanding and ongoing relationship to concepts of mental pathology, resulting in particularly complicated relationships between lesbian, gay, bisexual, queer, and trans (LGBTQ) people and understandings of ‘mental illness’ and ‘disorder.’ LGBTQ struggles for equity have in some ways hinged on claiming mental healthiness, albeit in different ways. Gay and lesbian activists in the 1970s successfully advocated for the removal of homosexuality and related diagnoses from the DSM, while trans activists continue to negotiate a relationship with psychiatry in order to have access to the technologies of medical transition. While these struggles are different, they make the shared claim that LGBTQ sexualities and genders are not ‘disordered.’²² This distancing of LGBTQ people from conceptualizations of ‘mental illness’ raises questions about the experiences of LGBTQ people who identify as having experienced mental distress or ‘illness.’

More recently, some scholars have claimed that LGBTQ people are not mentally ill by virtue of their gender and sexuality, but that homophobia, biphobia, and transphobia can create or contribute to ‘mental health problems’ (Chamberland and Saewyc, 2011; McIntyre, Daley, Rutherford, & Ross, 2011; Morrison, 2011; Rotondi, Bauer, Scanlon, Kaay, Travers & Travers, 2011; Rotondi, Bauer, Travers, Travers, Scanlon & Kaay, 2011). Meanwhile, mad studies scholars and theorists who emphasize social approaches to mental distress have challenged the very basis on which any of these arguments rest. These scholars question the merit of the biomedical model that posits that mental distress is indicative of underlying biogenetic disorders that can be scientifically evidenced and

²² As explained throughout, trans people must be labeled as ‘disordered’ in order to access the technologies of medical transition, whether or not we agree with this.

universally applied. Instead, they position the behaviours, experience, and thoughts that get called ‘mental illness’ as understandable responses to adversity and advocate non-medical ways of addressing and responding to them (Bracken et al, 2012; Coles, Keenan, & Diamond; Rapley, Moncrieff, & Dillon, 2011; Tew, 2006; Tew 2011). These inquiries can usefully inform LGBTQ perspectives about mental distress.

Located in mad studies, this dissertation examines the biomedical model of mental illness and social approaches to mental distress as they pertain to LGBTQ people. The study gives primacy to first-person accounts of people with lived experience rather than to medical experts, presenting the voices and viewpoints of 37 research participants who identify as LGBTQ and have experienced mental distress. Interviewed in two major Canadian cities, Toronto in Ontario and Winnipeg in Manitoba, these individuals offer distinct perspectives on the biomedical model of mental illness and social approaches to mental distress. In the first chapter I review some of the literature in mad studies, presenting a historiography of madness. This shows that ideas about the nature of madness change over time and are imbricated with perspectives on race, sexuality, and gender. I also examine more contemporary work in anti-psychiatry studies, lesbian and gay studies, queer studies, and trans studies that critique the biomedical model of mental illness and focuses on the impact of this model on those who have been psychiatrized. I argue that anti-psychiatry studies can be usefully informed by perspectives in lesbian and gay studies, queer studies, and trans studies that foreground LGBTQ issues, while the latter can learn from analyses of sanism in anti-psychiatry studies. I conclude by outlining the methodological issues relevant to my project.

The second chapter argues that the biomedical model fails to satisfactorily ‘make sense’ of the experiences, behaviours, and thought patterns that are classified as symptomatic of ‘mental disorders.’ As scholars who favour social approaches to mental distress argue, the biomedical model presents distress as ‘meaningless’ in that social context is considered irrelevant or secondary to biogenetic factors (Boyle, 2013; Coles, 2013). This results in tautological explanations for distress, whereby the symptoms indicate the existence of illness, and the existence of illness explains the symptoms (Boyle, 2013, p. 19). I present participant narratives regarding their dis/identifications with various terminologies which reveal critiques of the biomedical model. I argue that social approaches to mental distress are particularly helpful for understanding the experiences of marginalized groups, as they foreground and contextualize discrimination and structural oppression.

In chapter three I examine participants’ experiences with health care practitioners in order to look at the biomedical model in practice. I contend that biomedical service provision is based on inequitable power relations that can impede participants’ agency and self-determination. I show that practitioners are often uninformed about LGBTQ cultures and processes of racialization and racism, further creating problematic relations between service providers and LGBTQ people. Indeed, some practitioners pathologize LGBTQ people by positioning sexual and gender dissidence as deviant in various ways, including diagnosing sexual behaviour as ‘promiscuous’ and as symptomatic of ‘mental illness.’ Further, the mental health system and child protective services often act in tandem as tools of (neo)colonial regulation. This demonstrates that mental health care is

an enculturated process that reflects oppressive worldviews, rather than objective assessments of health and illness.

In chapter four, I examine Canada's first national mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, created by the Mental Health Commission of Canada. This document employs the notion of 'recovery' as a key concept informing changes to the Canadian mental health system. I focus on the sections of the strategy that deal with race, gender, and sexuality in order to examine how the state envisions 'recovery' for LGBTQ people. I argue that *Changing Directions, Changing Lives* fails to advance a strong structural understanding of how homophobia, transphobia, racism and other forms of oppression shape LGBTQ experiences of mental distress, access to services, and recovery. I compare this to participant narratives about the conditions that facilitate addressing mental distress, arguing that a focus on the social and structural factors that influence 'recovery' is crucial.

In the final chapter, I examine participants' experiences with employment, arguing that biomedical conceptions of 'mental illness' influence how the participants are seen in the workplace. While mainstream discourse positions race, gender identity, sexuality, and mental distress as neutral forms of social difference that have no impact on perceptions of competence at work, I argue that they in fact influence participants' opportunities to obtain and maintain work, job performance evaluations, and access to workplace accommodations. I draw on scholarly work about 'invisible' identities in order to show how participants must sometimes make difficult decisions about disclosing

information about mental distress, sexuality, and gender identity. I contend that such decisions are high stakes, given the impact on health and financial well-being.

My study raises interesting questions for future research. While there is an ever growing body of scholarship investigating possible biogenetic causes of ‘mental illness,’ there is a need for studies that centre social and structural factors, particularly those that are critical of biomedicalism as a way of understanding mental distress. As Tew (2011) argues, more research is needed regarding the ways in which “adverse social experiences” create mental distress and how “positive experiences” can facilitate recovery (p.269). As my study has shown, for LGBTQ people those adverse experiences are often related to oppression both within and outside of the mental health system. In terms of positive experiences, there are LGBTQ-specific questions to study, such as the ways in which involvement in queer and trans communities might provide support and opportunities for positive experiences. This research must be done with a critical perspective that is cognizant of the encroaching forces of neoliberalism that seek to saddle individuals and communities with financial and caretaking responsibilities.

There is also a need for more research that considers the complex interplay between social factors, biology, and embodiment. As Boyle (2013) argues, those who favour social approaches to mental distress focus on “life experiences and social context” and tend to ignore the body and the ways in which mental distress is “an embodied experience” (p. 6). She therefore calls for more “interactionist models” that consider “the inseparable, reciprocal relationships amongst the social, psychological and biological” and that take care not to position biology as the most authentic and “fundamental” part of the model (Boyle, 2013, p. 8).

Such research might further investigate the implications of Moncrieff's (2008) drug-centred approach outlined in chapter three. As discussed in more detail there, this approach understands psychotropic medication as creating “drug-induced effects that might relieve symptoms” rather than treating an underlying disease (Moncrieff, Cohen, & Mason, 2013, p. 229). Further research using this approach could examine the interactions between biological and social factors, centering the accounts of those who take such drugs. As Moncrieff, Cohen, and Mason (2013) argue, “listening to what people have to say about the effects induced by these drugs and how they impact on their lives is an important source of information” that is often ignored (p. 230).

The results of research that prioritizes social and structural factors contributing to mental distress could inform changes to service provision. While the predominance of the biomedical model of mental illness makes it difficult to conceptualize other ways of understanding mental distress, it is perhaps even more difficult to imagine what ‘mental health’ services would be if they were informed by alternative ideologies. One of the more pressing questions raised by my study is what social approaches to mental distress would look like in practice. What services might be possible if social and structural factors were seen as primary causes of mental distress? What would non-medical service provision look like? While there are some forms of psychiatry, psychology, and social work that do consider social factors, they are often informed by an underlying acceptance of the concept of ‘mental illness’ (Beresford, 2005; Poole et al, 2012). There may also be psychotherapists who operate from a social approaches perspective, but psychotherapy is often financially inaccessible as it is not covered by provincial health insurance.

As Coles, Keenan, and Diamond (2013) state, “freeing ourselves from established conventions of ideals, actions and professional customs can leave people feeling anxious and uncertain in how to make sense of madness, and how to help and offer support” (p. xii). While there are few examples to draw on in terms of financially accessible services that put social approaches into practice, there are some promising revolutionary approaches to service provision in or originating from the United Kingdom. I devote the space to describing three such examples because it is so hard to imagine possibilities beyond the biomedical model and because of the pressing nature of the question of what could possibly replace or compliment biomedical approaches to service provision.

Located in Leeds in West Yorkshire, England, the Leeds Survivor Led Crisis Service (LSLCS) was founded in 1999 by ‘mental health service users’ who wanted an alternative to services based on the biomedical model of mental illness. LSLCS offers a telephone helpline, support groups led by those with lived experience, and a house where those at “acute risk of suicide and/or self-injury” can stay (Venner & Noad, 2013, p. 334). This service takes a non-medical, non-diagnostic, anti-oppressive approach that posits that “deprivation and oppression not only impact on people’s ability to cope with distress, but can be the cause of distress” (Venner & Noad, 2013, p. 334). Behaviours that are considered symptomatic of an underlying disorder by biomedicalists, such as self-harm and a desire to commit suicide, are reframed as ways of dealing with distress. These behaviours are seen as making sense given the person’s circumstances, and those who use the LSLCS are seen as “trying their absolute best with the resources that they have and in the circumstances that they find themselves” (Venner & Noad, 2013, p.335). The LSLCS takes a ‘non-directive’ approach and manages risk through trusting service users and

working with them in a way that respects their agency. They have never had a serious violent incident, serious injury to staff or visitors, or death on their premises, despite working with many people in acute crisis (Venner & Noad, 2013, p. 339).

Similarly, the Hearing Voices Network (HVN), originating in Manchester in 1988, eschews biomedical definitions of what the DSM refers to as ‘schizophrenia’ and ‘psychosis.’ One of the central defining features of this form of mental distress is the experience of hearing voices. The HVN reframes this as “a normal human experience, that can be understood in the context of life events and interpersonal narratives, and which is often precipitated and maintained by events that overwhelm and disempower the individual” (Longden, Corstens & Dillon, 2013, p. 162). While biomedical approaches concentrate on eliminating the voices, the HVN advocates “understanding, accepting, and integrating their emotional meaning” (Dillon & Longden, 2012, p. 129). Support groups based on this philosophy have been created across 21 countries supported by Intervoice: The International Network for Training, Education and Research into Hearing Voices²³ (Dillon & Longden, 2012, p. 130). These groups are based on the shared experience of hearing voices rather than psychiatric diagnoses and can be led by those with lived experience rather than by mental health professionals without such experience. The groups are meant to provide a place where participants can begin the process of “recognizing and exploring possible meanings” that are being conveyed by the voices they hear in order to create a more positive relationship with them (Dillon & Longden, 2012, p. 132).

²³ The Intervoice website states that the development of a Hearing Voices Network is underway in Toronto, ON.

There is also a similar such group in Quebec City at a Francophone organization called Le Pavois. This organization has been supporting people who experience mental distress in achieving their goals in terms of employment and school since 1989. In 2005, Le Pavois started running a group based on the Hearing Voices model called ‘Mieux vivre avec les voix.’ The group meets on a weekly basis and devotes the first half of the session to sharing experiences and the second half to education about strategies for better understanding one’s voices and giving them meaning as well as international research regarding hearing voices. The website describes the group as a place where people can discover alternative understandings of the experience of hearing voices that are not based in psychiatry and begin to establish a relationship to their voices that works best for them.²⁴ Group members are also provided with one-on-one support from someone who works at Le Pavois, if they so desire. Le Pavois also offers awareness training to those who want to learn more about their approach, including hospitals and community centres (<http://www.lepavois.org/services/mieux-vivre-avec-les-voix/>).

The LSLCS, the HVN, and Mieux vivre avec les voix demonstrate innovative ways of implementing social approaches that provide valuable methods of addressing crisis and experiences of distress. These services position distress as an understandable response to life events and focus on finding meaning within the behaviours that manifest in response to such circumstances, rather than pathologizing and seeking to eliminate them. In many ways these services run counter to the logic that supports biomedical approaches, treating those who experience distress as agents in their own right who are making decisions that make sense within the context of their lives. Such services could

²⁴ A former participant of Mieux vivre avec les voix offers a version of this group in Ville de Trois-Rivières, Quebec called ‘Entendons-Nous’ (<http://www.robsm.org/Voix/index.html>).

inspire exciting possibilities for further developing such services in Canada. They could also inspire visions of similar services that are LGBTQ-specific, which could foster the growth of LGBTQ mad community.

Promoting social approaches in service provision is challenging, and as Tew (2011) argues, will require working to change larger social phenomena such as “social attitudes, media representations and wider policy discourses” (Tew, 2011, p. 170). This necessitates working for change beyond the mental health system in “mainstream services, employers, housing providers, communities and community leaders, policy makers” (Tew, 2011, p. 170). For LGBTQ communities, this indicates a role for community leaders and activists in determining what would best serve LGBTQ people and implementing changes in LGBTQ-focused services in community-based organizations.

There are also other interesting avenues for future research, such as the medicalization of various forms of experience and behaviour and the intersections with LGBTQ lives. The medicalization of addictions, especially because they are often characterized as ‘comorbid’ with ‘mental illness,’ is an area rife with opportunities for this kind of inquiry. How might social approaches change the way addictions are conceptualized and recovery services are organized? There are many ways in which queer and trans lives are specifically affected by the medicalization and pathologizing of addictions, not the least of which is the difficulty that trans people who use substances can have in accessing the technologies of medical transition. For example, the gender identity clinic at CAMH in Toronto, Ontario, requires that “any mental health or substance use issues are well-controlled” before providing approval for hormones and

surgery (CAMH, 2014). As this also indicates, there is more work to be done regarding the intersections between those deemed ‘unwell’ or ‘out of control’ in terms of ‘mental health’ and access to gender transition.

The pathologization and medicalization of bondage, discipline, domination, submission, sadism, and masochism (BDSM), leather communities, and kink practitioners is another related area of inquiry that merits further research. There are many diagnoses in the DSM that pathologize these practices, including sexual masochism disorder and sexual sadism disorder, amongst others. As I discussed in chapter three, LGBTQ people have a history of engaging in relationships, sexual experiences, and kinship ties that are outside of the heterosexual norm. This includes BDSM practices, and therefore LGBTQ people may be particularly affected by the pathologization of these practices. Relatedly, alternative styles of relationships such as non-monogamy and polyamory may also play a role in the pathologization of LGBTQ people. While I touched on this in chapter three, there is an area that could yield many interesting research results.

Future research might also consider different intersectional questions as they pertain to LGBTQ people who experience mental distress, such as the role of space and place. While my study found small but not hugely significant differences between the major Canadian cities of Winnipeg and Toronto, there may well be very different questions to explore in French Canada, on Indigenous reservations, in newcomer neighbourhoods and communities, in rural and small town Canada, and in Northern communities. Future intersectional inquiries might also foreground different vectors of power as they intersect in the lives of LGBTQ people who experience mental distress,

such as class, age, and physical disability. Transnational comparisons might also yield interesting results, including those made with other white settler nations. For example, comparisons with the United States might highlight the differences between experiencing distress in a country with a public healthcare system as opposed to a private healthcare system. Comparisons with countries in the global South might investigate the effects of “psychiatric imperialism” (Fernando, 2010). As Fernando (2010) argues, “Euro-American influence and political domination” in Asian and African countries has resulted in an imposition of western psychiatry and the “suppression of indigenous ways of dealing with human suffering, family problems and social disturbance” (p. 113). Transnational comparisons might look at the links between the ways in which this takes place within Canada with indigenous people and abroad.

Another potentially interesting area of study is the ways in which having a diagnosis of ‘mental illness’ or experiencing mental distress affects LGBTQ romantic and sexual relationships. Disabled bodies are often positioned as both abject and asexual, while those deemed ‘mentally ill’ are often perceived as dangerous and out of control (Anderson & Kitchin, 2000; Beresford, 2002; Milligan & Neufeldt, 2001). How do such stereotypes intersect with homophobia, transphobia, racism, and other forms of oppression? How do LGBTQ people who experience mental distress navigate such stereotypes in the disclosure of lived experience of distress to potential partners? Conversely, what supportive role can partners play in addressing mental distress for LGBTQ people? Relatedly, how do sanist notions about incapacity affect LGBTQ people who choose to parent? Given the relatively recent shifts in cultural mores that allow for more LGBTQ people to parent, how does sanism intersect with prejudicial beliefs

concerning the suitability of LGBTQ people as parents? How might being an LGBTQ person who experiences mental distress affect issues of child custody?

There are also interesting questions to consider regarding LGBTQ people who experience mental distress and the ways in which biomedicalism is mobilized by the state to police the boundaries of the nation. If a diagnosis of ‘mental illness’ is grounds for denying status in Canada, how does this affect LGBTQ people seeking entry in to the country? (Kanani 2012) How do the intersections between the pathologization of gender and sexual dissidence and mental distress affect LGBTQ immigrants, refugees, and newcomers? How do Western notions of mental health and illness operate as vectors of racism and imperialism in immigration regulations?

Further research might also explore the connections between mental distress and trauma and abuse. Some interesting work is already underway raising questions about whether what gets called ‘psychosis’ is in fact a response to abuse and trauma (Johnstone, 2011; Read et al, 2005). Johnstone (2011) calls for further analysis of “the ways in which people (can) react to trauma” and whether these “include some of the experiences we refer to as ‘hallucinations’ and ‘delusions’” (p. 109). Likewise, Plumb (2005) suggests that certain behaviours, feelings, and states of mind that typify responses to trauma and abuse have much in common with diagnostic criterion for various psychiatric conditions including obsessive compulsive disorder, neurotic disorder, bi-polar disorder, schizophrenia, and borderline personality disorder (p. 122). This leads her to questions whether “many psychiatric symptoms” are better understood as the ramifications of abuse and trauma (Plumb, 2005, p. 123). The answers to these questions could also inform service provision; indeed, Johnstone (2011) ponders whether “psychiatric services”

should be based on a trauma model rather than a biomedical model (p. 109). Given that some LGBTQ people experience abuse as part of homophobia and transphobia, these findings may be especially relevant to this group.

Further research might also consider the ways in which biomedicalism and neoliberalism structure institutional initiatives to address mental health concerns, such as those on post-secondary campuses. Research studies might consider how mental distress is understood and addressed in institutional contexts and the impact of increasingly popular ‘mental health awareness campaigns.’ As Kanani and Pilling (2014) argue, such initiatives tend to employ individualizing approaches that fail to account for structural barriers and the role of the university in creating conditions that can lead to mental distress. Our exploratory analysis of York University’s mental health strategy indicates that incidents of homophobic and transphobic violence, sexual assault, and racism on campus are treated as individual occurrences and as unconnected to student mental wellbeing. This context is erased in the university’s individualized recommendations for self-care to achieve good mental health (Kanani & Pilling, 2014). Future research might look at these issues in more depth, including more campuses as case studies and comparing these to other institutional contexts that might employ similar tactics, such as various workplace mental health initiatives.

The biomedical model is firmly entrenched within medical settings, but is also the dominant way of conceptualizing mental distress in the media, public policy, popular culture, and mainstream discourse. It therefore has far-reaching material effects on the lives of LGBTQ people who experience mental distress. There are many interesting directions for future research regarding the intersections between mental distress and

LGBTQ lives. As Coles, Keenan and Diamond (2013) argue, once madness is understood as directly related to the destructive “social structures” and “hierarchies we all live under,” it becomes apparent that there is a pressing need to explore the ways in which society can be restructured more equitably (p. xvi). Given the longstanding and ongoing relationship between ideas about ‘mental pathology’ and gender and sexual dissidence, these are issues of great importance to LGBTQ people. Indeed, LGBTQ communities can be seen as a place for such restructuring to continue.

Bibliography

- Agnew, V. (2007). *Interrogating race and racism*. Toronto, ON: University of Toronto Press.
- Agocs, C. & Jain, H.(2001). Systemic racism in employment in Canada: Diagnosing systemic racism in organizational culture. *Directions: Research reviews from the Canadian Race Relations Foundation*, 1(1), 11-29.
- Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., & Smye, V. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), 196–214.
- Anderson, J, Sapey, B, & Spandler, H. (2011). Proceedings from a symposium at Lancaster University: *Distress or Disability?* United Kingdom.
- Anderson, P., & Kitchin, R. (2000). Disability, space and sexuality: access to family planning services. *Social Science & Medicine*, 51(8), 1163–1173.
- Angus Reid Public Opinion. (2011). Most LGBT working Canadians experience tolerance but some discrimination persists. Retrieved from: <http://www.angus-reid.com/polls/44136/most-lgbt-working-canadians-experience-tolerance-but-some-discrimination-persists/>
- Badgett, M. L. (2003). *Money, myths, and change: The economic lives of lesbians and gay men*. Chicago: University of Chicago Press.
- Ballou, M., & Brown, L. S. (Eds.). (2002). *Rethinking mental health and disorder: Feminist perspectives*. New York, NY: Guilford Press.
- Barnes, C., Mercer, G., & Shakespeare, T. (1999). *Exploring disability: A sociological introduction* (pp. 10-38). Cambridge: Polity Press.
- Barton, L. (1996). *Disability and society: Emerging issues and insights*. Essex: Addison Wesley Longman.
- Baskin, C. (2007). Aboriginal youth talk about structural determinants as the causes of their homelessness. *First Peoples Child and Family Review*, 3(3), 31-42.
- Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, 20(5), 348–361.
- Bauer G, Nussbaum N, Travers R, Munro L, Pyne J, & Redman N. (2011). *We've got*

- work to do: Workplace discrimination and employment challenges for trans people in Ontario*. Retrieved from <http://www.transpulseproject.ca>.
- Bayer, R. (1987). *Homosexuality and American psychiatry*. Princeton, NJ: Princeton University Press.
- Beatty, J. E., & Kirby, S. L. (2006). Beyond the legal environment: how stigma influences invisible identity groups in the workplace. *Employee Responsibilities and Rights Journal*, 18(1), 29-44.
- Beckman, L & Davies, M. (2013). Democracy is a very radical idea. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 323-334). Toronto, ON: Canadian Scholars Press.
- Bell, C. (2006). Introducing white disability studies: a modest proposal. In L. J. Davis (Ed.), *The Disability Studies Reader*. New York, NY: Routledge.
- Bell, C. (2011). Introduction: Doing representational detective work. In C. Bell (Ed.), *Blackness and disability* (pp. 1-8). East Lansing, MI: University of Michigan Press.
- Bennett, M., Blackstock, C., & De La Ronde, R. (2005). A literature review and annotated bibliography on aspects of Aboriginal child welfare in Canada: Second Edition. *First Nations Child and Family Caring Society of Canada*. Accessed at http://cwrp.ca/sites/default/files/publications/en/AboriginalCWLitReview_2ndEd.pdf
- Bentall, R. P. (2003). *Madness explained: Psychosis and human nature*. New York, NY: Penguin.
- Beresford, P. (2000). What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability & Society*, 15(1), 167-172.
- Beresford, P. (2002). Thinking about 'mental health': towards a social model. *Journal of Mental Health*, 11(6), 581-584.
- Beresford, P. (2004). Madness, distress, research and a social model. In Barnes, C. & Mercer, G. (Eds.), *Implementing the social model of disability: Theory and research* (pp. 208-222). Leeds: The Disability Press.
- Beresford, P., Nettle, M., & Perring, R. (2010). *Exploring what service users say*. Retrieved from Joseph Rowntree Foundation website: <http://www.jrf.org.uk/sites/files/jrf/mental-health-service-models-full.pdf>.
- Beresford, P., & Wallcraft, J. (1997). Psychiatric system survivors and emancipatory research: issues, overlaps and differences. In C Barnes & G. Mercer (Eds.), *Doing disability research* (pp. 66-87). Leeds, The Disability Press.

- Biaggio, M., Roades, R., Staffelback, D., Cardinalli, J., & Duffy, R. (2000). Clinical evaluations: Impact of sexual orientation, gender, and gender role. *Journal of Applied Social Psychology*, 30(8), 1657-1669.
- Bland, L. & Doan, L. (1998). *Sexology uncensored*. Chicago, IL: University of Chicago Press.
- Boardman, J., Grove, B., Perkins, R., & Shepherd, G. (2003). Work and employment for people with psychiatric disabilities. *The British Journal of Psychiatry*, 182(6), 467-468.
- Bolaki, S. (2011). Challenging invisibility, making connections: Illness, survival, and black struggles in Audre Lorde's work. In C. Bell (Ed.), *Blackness and disability* (pp. 47-74). East Lansing, MI: University of Michigan Press.
- Bowleg, L., Brooks, K. & Ritz, SF. (2008). Bringing home more than a paycheck. *Journal of Lesbian Studies*, 12(1), 69-84.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist*, 20(5), 290-295.
- Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 27-44). New York, NY: Palgrave Macmillan.
- Boyle, M. (2013). The persistence of medicalisation: Is the presentation of alternatives part of the problem? In S. Coles, S. Keenan, & B. Diamond (Eds.), *Madness contested: Power and practice* (pp. 3-22). Heresfordshire: PCCS Books.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201(6), 430-434.
- Bradley, L. (2014, January 2014). Why improving workplace mental health is good business. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/globe-debate/why-improving-workplace-mental-health-is-good-business/article16364515/>
- Breggin, P. (2008). *Medication madness: The role of psychiatric drugs in cases of violence, suicide, and crime*. New York, NY: St Martin's Press.
- Broeck, S & Davis, L. (2011). Foreword and acknowledgements. In C. Bell (Ed.), *Blackness and disability* (pp. VII-XI). East Lansing, MI: University of Michigan Press.

- Browne, K., & Nash, C. J. (2010). *Queer methods and methodologies: Intersecting queer theories and social science research*. Surrey: Ashgate Publishing.
- Burnheimer, C & Kahane, C. (1985). *In Dora's case: Freud-hysteria-feminism*. New York: Columbia University Press.
- Busfield, J. (1996). *Men, women, and madness: Understanding gender and mental disorder*. New York: New York University Press.
- Burstow, B. (2013). A rose by any other name: Naming and the battle against psychiatry. In B.LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 79-90). Toronto, ON: Canadian Scholars Press.
- Burstow, B & Weitz, D. (Eds). (1988). *Shrink resistant: The struggle against psychiatry in Canada*. Vancouver, B.C.: New Star Books.
- Butler, J. (2004). *Undoing gender*. New York, NY: Routledge.
- Butler, R., & Bowlby, S. (1997). Bodies and spaces: an exploration of disabled people's experiences of public space. *Environment and Planning D*, 15, 411-434.
- Caldwell, K. (2010). We exist: intersectional in/visibility in bisexuality and disability. *Disability Studies Quarterly*, 30(3/4).
- Canadian Mental Health Association. (2012). Employment. Retrieved from <http://www.cmha.ca/mental-health/find-help/employment/>
- Canadian Mental Health Association. (2014). Mental illness in Canada: Statistics on the prevalence of mental disorders and related suicides in Canada. Retrieved from http://alberta.cmha.ca/mental_health/statistics/#.U7wtn0C8T3U
- Canadian Mood Disorders Society of Canada. (2009). Quick facts: Mental illness and addiction in Canada. Retrieved from: <http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Eng%20Nov%2012%2009.pdf>.
- Capponi, P. (2003). *Beyond the crazy house*. Toronto, ON: Penguin Books.
- Carpenter, C. S. (2008). Sexual orientation, work, and income in Canada. *Canadian Journal of Economics/Revue Canadienne D'économie*, 41(4), 1239–1261.
- Carr, S. (2005). 'The sickness label infected everything we said': Lesbian and gay perspectives on mental distress. In J. Tew (Ed.), *Social perspectives in mental health: Developing social models to understand and work with mental distress* (pp. 168-184). Philadelphia, PA: Jessica Kingsley Publishers.

- Centre for Addiction and Mental Health.(2012) Gender Identity Clinic: Criteria for those seeking hormones and/or surgery. Retrieved from http://www.camh.ca/en/hospital/care_program_and_services/hospital_services/Pages/gid_criteria_hormone_surgery.aspx
- Chamberland, L., & Saewyc, E. (2011). Stigma, vulnerability, and resistance: The psychosocial health of sexual minority and gender diverse people in Canada. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 30(2), 1–5.
- Chesler, P. (2005). *Women and madness*. New York, Palgrave Macmillan.
- Chunn, D. E., & Menzies, R. (1998). Out of mind, out of law: The regulation of criminally insane women inside British Columbia's public mental hospitals, 1888-1973. *Canadian Journal of Women and Law*, 10, 306-337.
- Church, K. (2001). Learning to walk between worlds: Informal learning in psychiatric survivor-run businesses: A retrospective re-reading of research process and results from 1993-1999. (Working Paper No. 20). Retrieved from Network for New Approaches to Lifelong Learning website: <http://nall.oise.utoronto.ca/res/20learningtowalk.htm>
- Canadian Mental Health Association. (2014). *Mental illness in Canada: Statistics on the prevalence of mental disorders and related suicides in Canada*. Retrieved from http://alberta.cmha.ca/mental_health/statistics/#.U_uZcKPCf3U
- Cohen, C. J. (2005). Punks, bulldaggers, and welfare queens: The radical potential of queer politics? In E. P. Johnson & M. G. Henderson (Eds.), *Black queer studies: A critical anthology* (pp. 21-51). Durham, NC: Duke University Press.
- Cohen, M., Goldberg, M., Istvanffy, N., Stainton, T., Adrienne Wasik., & Woods, K.M. (2008). *Removing barriers to work: Flexible employment options for people with disabilities in BC: Full research report*. Canadian Centre for Policy Alternatives, BC Office.
- Coles, S. (2013). Meaning, madness and marginalisation. In S. Coles S. Keenan, & B. Diamond (Eds.). *Madness Contested: Power and Practice* (pp. 42-55). Herefordshire: Pccs Books.
- Coles, S., Keenan, S., & Diamond, B. (2013). *Madness contested: Power and practice*. Herefordshire: Pccs Books.
- Connell RW. (2002) *Gender*, 2nd edition, Cambridge: Polity Press.
- Crossley, N. (2006). *Contesting psychiatry: Social movements in mental health*.

Abingdon, Oxon: Routledge.

- Daley, A., & Mule, N. (2010). *Queer lens of resistance: A critical anti-oppressive response to the DSM-V*. Paper presented at PsychOut: A Conference for Organizing Resistance Against Psychiatry, Toronto, ON. Retrieved from http://individual.utoronto.ca/psychout/papers/mule-et-al_paper.pdf
- Das Gupta, T. (2006). Racism and the labour movement. In D. Rayside, & G. Hunt (Eds.). *Equity, Diversity, and Canadian Labour* (pp 182-205). Toronto: University of Toronto Press.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459–470.
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65(2), 131–145.
- Davis, L. J. (1997, February). The encyclopedia of insanity: A psychiatric handbook lists a madness for everyone. *Harper's Magazine*.
- De Leeuw, S., Greenwood, M., & Cameron, E. (2010). Deviant constructions: How governments preserve colonial narratives of addictions and poor mental health to intervene into the lives of Indigenous children and families in Canada. *International Journal of Mental Health and Addiction*, 8, 282-296.
- Dhamoon, R. K., & Hankivsky, O. (2011). Why the theory and practice of intersectionality matter to health research and policy. In O. Hankivsky (Ed), *Health inequities in Canada: Intersectional frameworks and practices* (pp. 16–53). Vancouver: UBC Press.
- Diamond, S. (2011, November). What motivates sexual promiscuity? *Psychology Today*. Retrieved from <http://www.psychologytoday.com/blog/evil-deeds/201111/what-motivates-sexual-promiscuity>
- Diamond, S. (2013). What makes us a community? Reflections on building solidarity in anti-sanist praxis. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 64-77). Toronto, ON: Canadian Scholars Press.
- Dillon, J. (2011). The personal is the political. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 141-158). New York, NY: Palgrave Macmillan.
- Dillon, J., & Longden, E. (2012). Hearing voices groups: Creating safe spaces to share

- taboo experiences. In M. Romme & S. Escher (Eds.), *Psychosis as a personal crisis: An experience-based approach* (pp. 129-139). London: Routledge.
- Drake, R. F. (1999). *Understanding disability policies*. London: Palgrave Macmillan.
- Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the *Diagnostic and Statistical Manual*. *Archives of Sexual Behavior*, 39, 427–460.
- Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59–62.
- Edelman, L. (1994). *Homographesis: Essays in gay literary and cultural theory*. New York: Routledge.
- Ellis, H. (1901). *Studies in the psychology of sex Volume II: Sexual inversion*. Philadelphia, PA: F.A. Davis Company.
- England, K.V.L. (1994). Getting personal; reflexivity, positionality, and feminist research. *Professional Geographer*, 46, 80-89.
- Ehrenreich, B., & English, D. (1978). *For her own good: One hundred and fifty years of the experts' advice to women*. New York: Anchor Books.
- Fearnley, A.M. (2008). Primitive madness: re-writing the history of mental illness and race. *Journal of the History of Medicine and Allied Sciences*. 63(2), 245-257.
- Felski, R (1998). Introduction. In L. Bland & L. Doan (Eds). *Sexology in culture* (pp. 116-133). Chicago, IL: University of Chicago Press.
- Fernando, S. (2010). *Mental health, race and culture*. London: Palgrave Macmillan.
- Fine, M., & Kidder, L. (1997). Qualitative inquiry in psychology: A radical tradition. In D. Fox & I. Prilleltensky (Eds), *Critical psychology: An introduction* (pp. 34-50). California, CA: Sage.
- Foucault, M. (2006). *History of madness*. (J. Murphy & J. Khalfa, Trans.). New York, NY: Routledge. (Original work published 1961).
- Foucault, M. (1976). *The history of sexuality: Volume I*. New York, NY: Random House.
- Galabuzi, G. E. (2006). Canada's economic apartheid: The social exclusion of racialized groups in the new century. Toronto: Canadian Scholars Press.
- Gamson, J. (2000). Sexualities, queer theory, and qualitative research. In N. Denzin & Y.

- Lincoln (Eds), *Handbook of qualitative research* (pp. 347-361). California, CA: Sage.
- Gapka, S., Raj, R., Chow, K., Clipsham, J., Hampson, E., & MacDonnell, J. (2003). The trans health project (position paper). *Toronto: Ontario Public Health Association*.
- Garland-Thomson, R. (2002). Integrating disability, transforming feminist theory. *NWSA Journal*, 14(3), 1–32.
- Gilman, S. (1985). *Difference and pathology: Stereotypes of sexuality, race, and madness*. Ithaca, NY: Cornell University Press.
- GLAAD. (2010). Media reference guide, transgender glossary of terms. Retrieved from <http://www.glaad.org/reference/transgender>
- Gorman, R. (2013). Mad Nation? Thinking through race, class, and mad identity politics. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 269-280). Toronto, ON: Canadian Scholars Press.
- Gosine, K., & Pon, G. (2011). On the front lines: The voices and experiences of racialized child welfare workers in Toronto, Canada. *Journal of Progressive Human Services*, 22(2), 135–159.
- Grant, J.M., Mottet, L.A., Tanis, J.T., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey, executive summary*. Retrieved from the Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force website: Retrieved http://www.thetaskforce.org/downloads/reports/reports/ntds_summary.pdf
- Grillo, T., & Wildman, S. (1991). Obscuring the importance of race: The implication of making comparisons between racism and sexism (or other -isms). *Duke Law Journal*, 2, 397–412.
- Halberstam, J. (2011). *The queer art of failure*. Durham, NC: Duke University Press.
- Halley, D. (2010, June 10). The Pills Have Eyes: Microchipped Medicine is Coming. Retrieved from <http://singularityhub.com/2010/12/06/the-pills-have-eyes-microchipped-medicine-is-coming/>
- Harper, D., & Speed, E. (2012). Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice*, 6(1), 9–26.
- Harper, V. (1988). Them crazy Indians. In B. Burstow & D. Weitz (Eds.), *Shrink*

- resistant; The Struggle against psychiatry in Canada* (121-125). Vancouver: New Star Books.
- Henry, F & Tator, C. (2002). *Discourses of domination: Racial bias in the Canadian English-language press*. Toronto, ON: University of Toronto Press.
- Hilton, M. F., Scuffham, P. A., Vecchio, N., & Whiteford, H. A. (2010). Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity. *Australian and New Zealand Journal of Psychiatry*, 44(2), 151–161.
- Holland, K. (2007). The epistemological bias of ethics review. *Qualitative Inquiry*, 13(6), 895–913.
- Honey, A. (2004). Benefits and drawbacks of employment: perspectives of people with mental illness. *Qualitative Health Research*, 14(3), 381–395.
- Howell, A., & Voronka, J. (2012). Introduction: The politics of resilience and recovery in mental health care. *Studies in Social Justice*, 6(1), 1–7.
- Hughes, J. S. (1992). Labeling and treating Black mental illness in Alabama, 1861-1910. *The Journal of Southern History*, 58(3), 435–460.
- Hunt, G., & Eaton, J. (2007). We are family: Labour responds to gay, lesbian, bisexual, and transgender workers. In D. Rayside, & G. Hunt (Eds.). *Equity, diversity, and Canadian labour* (pp 130-155). Toronto: University of Toronto Press.
- Irvine, J. M. (2005). *Disorders of desire: Sexuality and gender in modern American sexology*. Philadelphia: Temple University Press.
- Jackson, A. (2000). The Myth of the Equity-Efficiency Trade-Off. *Canadian Council on Social Development*.
- Jackson, V. (2002). In our own voice: African-American stories of oppression, survival and recovery in mental health systems. *International Journal of Narrative Therapy & Community Work*, 2002(2), 11-31.
- Jacobson, N., Farah, D., & Toronto Recovery and Cultural Diversity Community of Practice. (2010). *Recovery through the lens of cultural diversity*. Retrieved from the Wellesley Institute website: <http://www.wellesleyinstitute.com/wp-content/uploads/2010/07/RTLCD-report-jul0410.pdf>
- Jagose, A. (1996). *Queer theory: An introduction*. New York: New York University Press.

- Jarman, M. (2011). Coming up from underground: Uneasy dialogues at the intersections of race, mental illness, and disability studies. In C. Bell (Ed.), *Blackness and disability* (pp. 9-30). East Lansing, MI: University of Michigan Press.
- Jeffreys, S. (2003). *Unpacking queer politics*. Cambridge: Polity Press.
- Jiwani, Y. (2006). *Discourses of denial: Mediations of race, gender, and violence*. Cambridge: Cambridge University Press.
- Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and 'psychosis.' In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 1-10). New York, NY: Palgrave Macmillan.
- Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. Philadelphia, PA: Routledge.
- Kanani, N. (November, 2012). Disabling identities; Considering the role of race, gender, and status in accessing health and disability services. Paper presented at the meeting of York University's Ontario Public Interest Research Group, Toronto, ON.
- Kanani, N. (2011). Race and madness: Locating the experiences of racialized people with psychiatric histories in Canada and the United States. *Critical Disability Discourse*, 3, 1-14.
- Kanani, N., & Pilling, M. (2014). *The student mental health crisis? Managing structural violence and student wellbeing through university mental health strategies*. Paper presented at the annual Critical Disability Studies Association conference. St Catharines, ON.
- Khan, C. (2006). 'The blind spot': Racism and discrimination in the workplace. In J. S. Frideres (Ed.), *Our diverse cities* (pp.61-65). Retrieved from http://canada.metropolis.net/research-policy/cities/publication/diverses_cites_vol2_e.pdf#page=63
- Khosla, P. (2008). If low-income women of colour counted in Toronto. In M. Wallis & S. Kwok (Eds.). *Daily struggles: The deepening racialization and feminization of poverty in Canada*. Toronto: Canadian Scholars Press.
- Kielburger, C. & Kielburger, M. (2013, August 19). Cultural respect is a health issue for Canadian Aboriginals. *Ottawa Citizen*. Retrieved from <http://www.ottawacitizen.com/health/Cultural+respect+health+issue+Canadian+aboriginals/8803694/story.html>
- Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of

- disorder. *Evidence Based Mental Health*, 16(2-3), 2-3.
- Kirky, S. (2012, May 8). Mental health strategy calls for significant cash boost to address crisis. *Postmedia News*. Retrieved from:
<http://www.canada.com/health/Mental+health+strategy+calls+significant+cash+boost+address+crisis/6578829/story.html>
- Kirsh, B. (2000). Work, workers, and workplaces: A qualitative analysis of narratives of mental health consumers. *The Journal of Rehabilitation*, 66(4), 24-30.
- Koerner, N., Dugas, M. J., Savard, P., Gaudet, A., Turcotte, J., & Marchand, A. (2004). The economic burden of anxiety disorders in Canada. *Canadian Psychology/Psychologie Canadienne*, 45(3), 191.
- Kooistra, A. (2008). Speaking into sight: articulating the body personal with the body politic. *Vis-à-vis: Explorations in Anthropology*, 8(1), 1-17.
- Krafft-Ebing, R.V. (1886). *Psychopathia sexualis: With especial reference to the antipathic sexual instinct: A medico-forensic study*. New York, NY: Stein and Day.
- Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*, 84(6), 782–787.
- Kurk, S., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. New York: Aldine.
- Kurk, S., & Kutchins, H. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*. New York: Free Press.
- Laing, R. D. (1965). *The divided self: An existential study in sanity and madness*. London: Penguin.
- Lapsley, H., Nikora, L. W., & Black, R. M. (2002). “Kia mauri tau!” Narratives of recovery from disabling mental health problems. Commissioned Report for External Body. Retrieved March 3, 2012, from
<http://researchcommons.waikato.ac.nz/handle/10289/1666>
- LeFrançois, B. A., Menzies, R., & Reaume, G. (2013). *Mad matters: A critical reader in Canadian mad studies*. Toronto: Canadian Scholars’ Press.
- Lester, H., & Tritter, J. Q. (2005). “Listen to my madness”: Understanding the experiences of people with serious mental illness. *Sociology of health & illness*, 27(5), 649–669.

- Lev, A.I. (2005). Disordering gender identity: gender identity disorder in the DSM-IV-TR. *Journal of Psychology and Human Sexuality*, 17(3/4), 35-69.
- Lewis, B. (2006). *Moving beyond Prozac, DSM, and the new psychiatry: The birth of postpsychiatry*. Ann Arbor, MI: University of Michigan Press.
- Li, P. S. (2008). The market value and social value of race. In M. Wallis & S. Kwok (Eds.), *Daily struggles: The deepening racialization and feminization of poverty in Canada* (pp.21-34). Toronto, ON: Canadian Scholars' Press.
- Lim, K. L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C. S. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada*, 28(3), 92–98.
- Lingsom, S. (2008). Invisible impairments: dilemmas of concealment and disclosure. *Scandinavian Journal of Disability Research*, 10(1), 2-16.
- Llorca, P.M. (2008). Partial compliance in schizophrenia and the impact on patient outcomes. *Psychiatry Research*, 161(2), 235-247.
- Longden, E., Corstens, D., & Dillon, J. (2013). Recovery, discovery and revolution: The work of Intervoice and the hearing voices movement. In S. Coles, S. Keenan, & B. Diamond (Eds.), *Madness contested: Power and practice* (pp. 161–180). Heresfordshire: PCCS Books.
- Lunbeck, E. (1994). *The psychiatric persuasion: Knowledge and power in modern America*. Princeton, NJ: Princeton University Press.
- Manning, C., & White, P. D. (1995). Attitudes of employers to the mentally ill. *Psychiatric Bulletin*, 19(9), 541–543.
- Marecek, J. & Gavey, N. (2013). DSM-5 and beyond: A critical feminist engagement with psychodiagnosis. *Feminism & Psychology*, 23(1,) 3-9.
- May, R. (2007). Working outside the diagnostic frame. *The Psychologist*, 20(5), 300-301.
- McDowell, L. (1992). Doing gender: Feminism, feminists and research methods in human geography. *Transactions, Institute of British Geographers*, 17, 399-416.
- McFarlane, L. (1998). Diagnosis: Homophobic: The experiences of lesbians, gay men and bisexuals in mental health services. Project for Advice, Counselling and Education (PACE), London. Retrieved from <http://www.pacehealth.org.uk/PACE%20Diagnosis-Homophobic.pdf>
- McIntyre, J., Daley, A., Rutherford, K., & Ross, L. E. (2011). Systems-level barriers in

- accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 30(2), 173-186.
- Mental Health Commission of Canada. (2011). *The life and economic impact of major mental illnesses in Canada*. Retrieved from <http://www.mentalhealthcommission.ca/English/node/5024>
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB.
- Mental Health Commission of Canada. (2013). *Why investing in mental health will contribute to Canadian economic prosperity*. Retrieved from <http://strategy.mentalhealthcommission.ca/pdf/case-for-investment-en.pdf>
- Menzies, R., & Chunn, D. E. (2002). Race, reason, and regulation: British Columbia's mass exile of Chinese 'lunatics' aboard the Empress of Russia, 9 February 1935. In J. P. S. McLaren, R. Menzies & D.E. Chunn (Eds.), *Regulating lives: Historical essays on the state, society, the individual, and the law* (196–230) Vancouver: UBC Press.
- Menzies, R., & Palys, T. (2006). Turbulent spirits: Aboriginal patients in the British Columbia psychiatric system, 1879-1950. In J. Moran & D. Wright (Eds.), *Mental health and Canadian society: historical perspectives* (pp.149–75). Montreal: McGill-Queen's University Press.
- Metzl, J. (2009). *The protest psychosis: How schizophrenia became a black disease*. Boston, MA: Beacon Press.
- Miles, R. (1989). *Racism*. London: Routledge.
- Milligan, M. S., & Neufeldt, A. H. (2001). The myth of asexuality: A survey of social and empirical evidence. *Sexuality and Disability*, 19(2), 91–109.
- Minton, H. (2002). *Departing from deviance: A history of homosexual rights and emancipatory science in America*. Chicago, IL: University of Chicago Press.
- Mollow, A. (2006). When black women start going on Prozac: Race, gender, and mental illness in Meri Nana-Ama Danquah's "Willow Weep for Me." *Melus*, 31(3), 67–99.
- Mollow, A. & McRuer, R. (2012). *Sex and disability*. Durham, NC: Duke University Press.
- Moncrieff, J. (2008) *The myth of the chemical cure: A critique of psychiatric drug treatment*. Hampshire: Palgrave Macmillan.

- Moncrieff, J., Cohen, D., & Mason, J. (2013). The patient's dilemma: An analysis of users' experiences of taking neuroleptic drugs. In S. Coles, S. Keenan, & B. Diamond (Eds.), *Madness contested: Power and practice* (pp. 3-22). Heresfordshire: PCCS Books.
- Morrison, M. (2011). Psychological health correlates of perceived discrimination among Canadian gay men and lesbian women. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 30(2), 81-98.
- Morrow, M. (2013). Recovery: Progressive paradigm or neoliberal smokescreen? In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 323-334). Toronto, ON: Canadian Scholars Press.
- Morrow, M. & J. Weisser. (2012). Towards a social justice framework of mental health recovery. *Studies in Social Justice*, 6(1), 27-43.
- Morrow, M., Wasik, A., Cohen, M., & Perry, K.-M. E. (2009). Removing barriers to work: Building economic security for people with psychiatric disabilities. *Critical Social Policy*, 29(4), 655-676.
- Mosher, L. & Boyle, M. (n.d.). A Fast for Freedom in Mental Health: Rethinking the Mental Illness Industry. Retrieved from <http://campaignfortruth.com/Eclub/220903/mentalhealth.htm>
- Mulvany, J. (2000). Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness*, 22(5), 582-601.
- Obedin-Maliver. (2011). Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *The Journal of the American Medical Association*, 306(9), 971-977.
- Oliver, M. (1992). Changing the social relations of research production? *Disability, Handicap & Society*, 7(2), 101-114.
- Oliver, M. (1990). *The politics of disablement: A sociological approach*. London: Palgrave Macmillan.
- Oliver, M. (1995). *Understanding disability: From theory to practice*. London: Palgrave Macmillan.
- Ornstein, M. D. (2000). *Ethno-racial inequality in the City of Toronto: Analysis of the 1996 Census*. Project Steering Committee for the Study on Ethno Racial Inequality. Retrieved from http://tobiashouse.ca/passport/profiles/pdf/Ethno-Racial_Inequality.pdf

- Perlin, M. L. (2002). You have discussed lepers and crooks: Sanism in clinical teaching. *Clinical Law Review*, 9, 683-730.
- Peters, H., & Brown, T. C. (2009). Mental illness at work: An assessment of co-worker reactions. *Canadian Journal of Administrative Sciences/Revue Canadienne des Sciences de l'Administration*, 26(1), 38-53.
- Plumb, A. (1994). *Distress Or disability?: A discussion document*. Manchester: Greater Manchester Coalition of Disabled People Publications
- Plumb, S. (2005). The social/trauma model: Mapping the mental health consequences of childhood sexual abuse and similar experiences. In J. Tew (Ed.), *Social perspectives in mental health: Developing social models to understand and work with mental distress* (pp. 168-184). Philadelphia, PA: Jessica Kingsley Publishers.
- Price, M. (2010). *Mad at school: Rhetorics of mental disability and academic life*. East Lansing, MI: University of Michigan Press.
- Puxley, C. (2013, August 29). Brian Sinclair: Man who died after 34-hour Winnipeg hospital wait was assumed to be 'sleeping it off' after vomiting. *The Canadian Press*. Retrieved from http://www.thestar.com/news/canada/2013/08/29/brian_sinclair_man_who_died_after_34hour_winnipeg_hospital_wait_was_assumed_to_be_sleeping_it_off_after_vomiting.html
- Phillips, R. (2006). Consumer participation in mental health research. *Social Policy Journal of New Zealand*, 27, 171-182.
- Pilgrim, D. (2008). 'Recovery' and current mental health policy. *Chronic Illness*, 4(4), 295-304.
- Pon, G. (2009). Cultural competency as new racism: An ontology of forgetting. *Journal of Progressive Human Services*, 20(1), 59-71.
- Poole, J. (2011). *Behind the rhetoric: Mental health recovery in Ontario*. Winnipeg, MB: Fernwood Publishing.
- Poole, J., Jivraj, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., Reid, J. (2012). Sanism, 'mental health' and social work/education: A review and call to action. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity and Practice*, 1(1), 20-36.
- Poole, S. (2013, December 11). Why the cult of hard work is counter-productive [Blog entry]. Retrieved from <http://www.newstatesman.com/2013/12/right-be-lazy>

- Porter, R. (2002). *Madness: A brief history*. New York, NY: Oxford University Press.
- Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 26(2), 132–144.
- Ragins, B., Cornwell, J., & Miller, J. (2003). Heterosexism in the workplace: Do race and gender matter? *Group & Organization Management*, 28(1), 45–74.
- Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: Fear and disclosure of sexual orientation at work. *Journal of Applied Psychology*, 92(4), 1103-1118.
- Rapley, M. (2012). W(h)ither DSM? *Mauritas*, 73(2), 81-82.
- Rapley, M., Moncrieff, J., & Dillon, J. (2011). Carving nature at its joints? DSM and the medicalization of everyday life. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 1-10). New York, NY: Palgrave Macmillan.
- Rayside, D. (2007). Equity, diversity, and Canadian labour: A comparative perspective. In D. Rayside, & G. Hunt (Eds.). *Equity, diversity, and Canadian labour* (pp 208-230). Toronto: University of Toronto Press.
- Read, J., & Haslam, N. (2004). Public opinion: Bad things happen and can drive you crazy. In J. Read, L. Mosher, & R. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia* (pp.133-147). Sussex: Brunner-Routledge.
- Read, J., Os, J. Van, Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112(5), 330–350.
- Reaume, G. (2000). *Remembrance of patients past: Life at the Toronto Hospital for the Insane, 1870-1940*. Toronto, ON: Oxford University Press Canada.
- Reaume, G. (2002). Lunatic to patient to person: nomenclature in psychiatric history and the influence of patients' activism in North America. *International Journal of Law and Psychiatry*, 25(4), 405-426.
- Reaume, G. (2004). No profits, just a pittance: Work, compensation and people defined as mentally disabled in Ontario, 1964-1990. In S. Noll & J. W. Trent Jr. (Eds), *Mental retardation in America: A historical reader* (pp. 466-493). New York, NY: New York University Press.
- Reaume, G. (2006). Mad people's history. *Radical History Review* 94, 170-182.

- Reinharz, S. (1992). *Feminist methods in social research*. New York, NY: Oxford University Press.
- Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. London: Bailliere Tindall.
- Reville, D & Church, K. (2012). Mad activism enters its fifth decade: Psychiatric survivor organizing in Toronto. In A. Choudry, J. Hanley & E. Shragge (Eds), *Organize!: Building from the Local for Global Justice*. Oakland, CA: PM Press.
- Risman, B. J. (2010). Gender as a social structure: Theory wrestling with activism. In J. E. Spade & C. G. Valentine (Eds.), *The kaleidoscope of gender: Prisms, patterns and possibilities* (pp. 9-20). Thousand Oaks, CA: Sage Publications.
- Robinson, A. (1994). It takes one to know one: passing and communities of common interest. *Critical Inquiry*, 20(4), 715-736.
- Rogers, A., & Pilgrim, D. (2010). *A sociology of mental health and illness*. Berkshire: Open University Press.
- Rose, N. (1999). *Powers of freedom: Reframing political thought*. Cambridge: Cambridge university press.
- Rossiter, K., & Morrow, M. (2011). Intersectional frameworks in mental health: Moving from theory to practice. In O. Hankivsky (Ed), *Health Inequities in Canada: Intersectional Frameworks and Practices* (pp. 312–330). Vancouver: UBC Press.
- Rotondi, N. K., Bauer, G. R., Scanlon, K., Kaay, M., Travers, R., & Travers, A. (2011). Prevalence of and risk and protective factors for depression in female-to-male transgender Ontarians: Trans PULSE Project. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 30(2), 135-155.
- Rotondi, N. K., Bauer, G. R., Travers, R., Travers, A., Scanlon, K., & Kaay, M. (2011). Depression in male-to-female transgender Ontarians: Results from the Trans PULSE Project. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, 30(2), 113-133.
- Ruesch, J. (1962). Myth of mental illness by Thomas Szasz. *Arch Gen Psychiatry*, 6(1), 103-105.

- Rutherford, K., McIntyre, J., Daley, A., & Ross, L. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education*, 46, 903-913.
- Ryan, B. (2003). A new look at homophobia and heterosexism in Canada. Discussion paper commissioned by the Canadian AIDS Society. Retrieved from: [http://www.cdnaids.ca/files.nsf/pages/homophobiareport_eng/\\$file/homophobia%20report_eng.pdf](http://www.cdnaids.ca/files.nsf/pages/homophobiareport_eng/$file/homophobia%20report_eng.pdf)
- Saguy, A. C., & Ward, A. (2011). Coming out as fat: Rethinking stigma. *Social Psychology Quarterly*, 74(1), 53-75.
- Samuels, E. (2003). My body, my closet: invisible disability and the limits of coming-out discourse. *GLQ*, 9(1-2), 233-255.
- Scholinski, D. (1997). *The last time I wore a dress: A memoir*. New York, NY: Riverhead Books.
- Schrader, S., Jones, N., & Shattell, M. (2013). Mad pride: Reflections on sociopolitical identity and mental diversity in the context of culturally competent psychiatric care. *Issues in Mental Health Nursing* 34(1), 62-64.
- Scott-Samuel, A., Stanistreet, D., & Crawshaw, P. (2009). Hegemonic masculinity, structural violence and health inequalities. Retrieved from <http://www.tandfonline.com/doi/abs/10.1080/09581590903216420>
- Sedgwick, E. (1993). *Tendencies*. Durham, NC: Duke University Press.
- Shakespeare, T. (1996a). Disability, identity and difference. In C. Barnes, & G. Mercer (Eds.), *Exploring the divide: Illness and disability* (pp. 94-113). Leeds: The Disability Press.
- Shakespeare, T. (1996b) Rules of engagement: Doing disability research. *Disability and Society* 11, 115-120.
- Shakespeare, T. & Watson, N. (2002). The social model of disability: an outdated ideology? *Research in Social Science and Disability*, 2, 9-28.
- Shields, S. (2008). Gender: an intersectionality perspective. *Sex Roles*, 59, 301-311.
- Shier, M., Graham, J. R., & Jones, M. E. (2009). Barriers to employment as experienced by disabled people: a qualitative analysis in Calgary and Regina, Canada. *Disability & Society*, 24(1), 63-75.
- Shimrat, I. (1997). *Call me crazy: Stories from the mad movement*. Vancouver, BC:

- Press Gang Publishers.
- Silver, J. (2004, November). Community development in Winnipeg's inner city. *Canadian Dimension*, 38(6). Retrieved from <http://www.canadiandimension.com/articles/1951>.
- Showalter, E. (1985). *The female malady*. New York: Penguin.
- Small, S. (1999). The contours of racialization structures: Structures, representations, and resistance in the United States. In R.D. Torres, L.F. Mirón and J. X. Inda (Eds.), *Race, identity, and citizenship: A reader*. (pp. 47-64). Cambridge, MA: Blackwell Publishers.
- Smith, D. E., & David, S. J. (1975). *Women look at psychiatry*. Vancouver, B.C.: Press Gang Publishers.
- Smith-Rosenberg, C. (1986). *Disorderly conduct: Visions of gender in Victorian America*. New York: Oxford University Press.
- Smye, V., & Browne, A. J. (2002). "Cultural safety" and the analysis of health policy affecting aboriginal people. *Nurse Researcher*, 9(3), 42.
- Somerville, S.B. (2000). *Queering the color line: Race and the invention of homosexuality in American culture*. Durham, NC: Duke University Press.
- Spade, D. (2011). Normal life: Administrative violence, critical trans politics and the limits of law. Brooklyn, NY: South End Press.
- Spade, D. (2006). Mutilating gender. In S. Stryker and S. Whittle (Eds.), *The transgender studies reader*. (pp. 315-332) New York: Routledge.
- Speed, E. (2011). Discourses of acceptance and resistance: Speaking out about psychiatry. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 123-141). New York, NY: Palgrave Macmillan.
- Statistics Canada. (2006). Aboriginal population profile for Winnipeg. Retrieved from <http://www.statcan.gc.ca/pub/89-638-x/2010003/article/11082-eng.htm>
- Statistics Canada. (2013a). Backgrounder for the 2011 National Household Survey: Immigration, Citizenship, Place of Birth, Ethnicity, Visible Minorities, Religion and Aboriginal Peoples. Retrieved from http://www1.toronto.ca/city_of_toronto/social_development_finance_administration/files/pdf/nhs_backgrounder.pdf
- Statistics Canada. (2013b). Winnipeg, CY, Manitoba (Code 4611040) (table). National

- Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa. Released September 11, 2013. Retrieved from <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E>
- Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General psychiatry*, 55(5), 393-401.
- Stewart, S. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion and Education*, 46(2), 49-56.
- Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry*, 19(5), 522.
- Swain, J., Cameron, C., Corker, M., & French, S. (1999). Unless otherwise stated: discourses of labeling and identity in coming out. In M. Corker & S. French (Eds.), *Disability discourse* (pp.68–78). Buckingham: Open University Press.
- Szasz, T. (1970). *The manufacture of madness: A comparative study of the inquisition and the mental health movement*. New York, NY: Harper and Row.
- Tam, L. (2013). Whither Indigenizing the mad movement? Theorizing the social relations of race and madness through conviviality. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 281-297). Toronto, ON: Canadian Scholars Press.
- Taylor, N. (2008, September 30). DSM invests in microchip compliance packaging. Retrieved from <http://www.in-pharmatechnologist.com/Drug-Delivery/DSM-invests-in-microchip-compliance-packaging>
- Terry, J. (1999). *An American obsession: Science, medicine, and homosexuality in modern society*. Chicago, IL: University of Chicago Press.
- Tew, J. (2005). *Social perspectives in mental health: Developing social models to understand and work with mental distress*. Philadelphia, PA: Jessica Kingsley Publishers.
- Tew, J. (2011). *Social approaches to mental distress*. New York, NY: Palgrave Macmillan.
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work*, 42(3), 443–460.

- Thomas, P. (2013). Pinball wizards and the doomed project of psychiatric diagnosis. *Mad in America: Science, Psychiatry and Community*. Retrieved from <https://www.madinamerica.com/2013/02/pinball-wizards-and-the-doomed-project-of-psychiatric-diagnosis/>
- Tierney, S. (2002). Anorexia: Illuminating impairment or dishonourable disability? *Disability Studies Quarterly*, 22(3).
- Tucker, I. (2009). 'This is for life': A discursive analysis of the dilemmas of constructing diagnostic identities. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 10(3).
- Ussher, J. M. (1992). *Women's madness: misogyny or mental illness?* Amherst, MA: University of Massachusetts Press.
- Ussher, J. M. (2011). *The madness of women*. New York: Routledge.
- Valentine, G. (2002). People like us: negotiating sameness and difference in the research process. *Feminist Geography in Practice: Research and Methods*, 116–26.
- Valeras, A. B. (2010). "We don't have a box": understanding hidden disability identity utilizing narrative research methodology. *Disability Studies Quarterly*, 30(3/4).
- Venner, F, & Noad, M. (2013). A beacon of hope: Alternative approaches to crisis – learning from Leeds Survivor Led Crisis Service. In S. Coles S. Keenan, & B. Diamond (Eds.). *Madness contested: Power and practice* (pp. 332-348). Herefordshire: Pccs Books.
- Vermette, L. The 33 years of the lost Indian walk. In B. Burstow & D. Weitz (Eds.), *Shrink resistant: The struggle against psychiatry in Canada* (pp.117-120). Vancouver: New Star Books.
- Vlasnik, J., Aliotta, S., & DeLor, B. (2005). Medication adherence: Factors influencing compliance with prescribed medication plans. *The Case Manager*, 16(2), 47-51.
- Waldram, J. (2004). *Revenge of the windigo: The construction of the mind and mental health of North American Aboriginal peoples*. Toronto, Ontario: University of Toronto Press.
- Waldron, I.R.G. (2003). *African Canadian women storming the barricades: Challenging psychiatric imperialism through indigenous conceptualizations of mental illness and self-healing*. Michigan: UMI Dissertation Services.
- Walker, L. (2001). *Looking like what you are: Sexual style, race, and lesbian identity*. New York, NY: New York University Press.

- Warner, D. N. (2004). Towards a queer research methodology. *Qualitative Research in Psychology*, 4(1), 321-337.
- Warner, M. (1999). *The trouble with normal: Sex, politics, and the ethics of queer life*. Cambridge, MA: Harvard University Press
- Weisser, J., Jamer, B., & Morrow, M. (2011). *A critical exploration of social inequities in the mental health recovery literature*. Centre for the Study of Gender, Social Inequities and Mental Health, Simon Fraser University. Retrieved from http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/02/Recovery-Scoping-Review.Final_.STYLE_.pdf
- Weeks, J. (1985). *Sexuality and its discontents: Meanings, myths & modern sexualities*. London: Routledge.
- White, K. (2009). Out of the shadows and into the spotlight: The politics of (in)visibility and the implementation of the mental health commission of Canada. In K. White (Ed). *Configuring madness: Representation, context & meaning* (pp. 225-249). Oxford, U.K.: Inter-Disciplinary Press.
- White, K & Pike, R. (2013). The making and marketing of mental health literacy in Canada. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 239-252). Toronto, ON: Canadian Scholars Press.
- Wilton, R. D. (2004). Keeping your distance: Balancing political engagement and scientific autonomy with a psychiatric consumer/survivor group. In D. Fuller & R. Kitchin (Eds.) *Radical geography/critical praxis: Making a difference beyond the academy* (pp.116-131). Victoria, BC: Praxis (e)Press.
- Wilton, R. (2004). Putting policy into practice? Poverty and people with serious mental illness. *Social Science & Medicine*, 58(1), 25–39.
- Winters, K. (2008). *Gender madness in American psychiatry: Essays from the struggle for dignity*. Colorado: GID Reform Advocates.
- Yellow Bird, P. (2004). Wild Indians; Native perspectives on the Hiawatha Asylum for insane Indians. Retrieved May 18, 2012 from <http://www.patdeegan.com/pdfs/PeminasManuscript.pdf>.
- Young, R. (1995). *Colonial desire: Hybridity in theory, culture, and race*. London: Routledge.

Appendix A

Age	20s: 51% 30s: 35% 40s: 14%
Gender	female: 49% (32% non-trans, 17% trans ²⁵) male: 38% (50% non-trans, 50% trans) neither male nor female: 5%
Sexuality	queer: 62% gay: 22% lesbian: 13% bisexual: 8% pansexual: 5% heterosexual: 3%
Race/Ethnicity	white: 59% racialized: 41%
Class	low income: 51% middle class: 49%
Disability	physical or mental disability: 51% able-bodied: 49%

Explanation: The research participants were between the ages of 20 and 49, with 51% in their 20s, 35% in their 30s, and 14% in their 40s. In terms of gender, 49% of participants identified as female and 38% identified as male. Of the female participants, 17% also identified as trans and/or genderqueer, as did 50% of the male participants. The remaining 5% of participants did not specify either male or female, identifying simply as trans and/or genderqueer. Many participants used more than one term to describe their sexuality; 62% identified as queer, 22% as gay, 13% as lesbian, 8% as bisexual, 5% as pansexual/omnisexual, and 3% as heterosexual. The participants also used many terms to describe their race and ethnicity, but broadly speaking, 59% of participants identified as white, and 41% identified as racialized. In addition to identifying as white, 5% identified as French Canadian, 5% as Eastern European, 3% as Western European, 3% as Scottish, and 3% as Jewish. Of the participants who are racialized, 11% identified as black, 11% as Métis, 11% as mixed race/biracial, 5% as Aboriginal, 3% as brown, 3% as Korean, 3% as East Asian, 3% as South Asian, 3% as Middle Eastern, 3% as Indonesian, and 3% as Muslim. Just over half of the participants (51%) identified as low income,

²⁵ I use the term ‘trans’ as an umbrella term that includes trans, transgender, transsexual, and genderqueer people.

and the remaining 49% identified as middle class. In terms of disability, 51% of participants identified as having one or more physical and/or mental disabilities. It is important to note that the percentages for sexuality and race do not add up to 100 because many participants identified with more than one term.