

# CanadaWatch

PRACTICAL AND AUTHORITATIVE ANALYSIS OF KEY NATIONAL ISSUES

## CRITICAL PERSPECTIVES ON MENTAL HEALTH/MAD STUDIES

### Director's introduction

The Robarts Centre for Canadian Studies at York University is one of the university's 27 organized research units (ORUs), providing a home for research outside traditional academic units and moving research beyond departments and disciplines. At York, the Robarts Centre is the research engine for the collaborative and critical study of Canada. In its 2015–2020 charter, the centre linked its strategic research priorities to the growth and development of its research clusters. A central focus of Robarts has been on expanding research capacity through the development of new and dynamic clus-

BY GABRIELLE SLOWEY



**Gabrielle Slowey is an associate professor in the Department of Politics at York University and director of the Robarts Centre for Canadian Studies.**

ters. Robarts has indeed become a hub for research, with the research clusters akin to airlines operating out of a central terminal. The clusters reflect the diversity of Canadian studies in their scope, subject, and methodology, and they have become a significant source of growth for the centre in attracting grants, participation, and attention. As it has responded to researchers' requests to meet the centre's mandate, Robarts has become something of a research broker, connecting faculty, students, and the community under the rubric of research. Its focus

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## CO-EDITORS' INTRODUCTION

# Introduction to Canada Watch: Critical Perspectives on Mental Health/Mad Studies

In 2019 the Robarts Centre for Canadian Studies invited us to establish a research cluster on Critical Perspectives on Mental Health/Mad Studies. The Robarts Centre had already been a generous supporter of our research on the Madness Canada/Folie Canada website, our online education site, *History in Practice*, the 2018 Mad Cities past–present exhibit in Vancouver's Downtown Eastside, and our 2013 documentary *The Inmates Are Running the Asylum* (all available on [madnesscanada.com](http://madnesscanada.com)). The time was ripe to pull in York's critical mental health/Mad Studies community more broadly. And thus the cluster was born.

BY MARINA MORROW, CINDY JIANG, SIMON ADAM, AND MEGAN DAVIES

**Marina Morrow is a professor at the School of Health Policy and Management in the Faculty of Health at York University.**

**Cindy Jiang is a research associate at the Robarts Centre for Canadian Studies.**

**Simon Adam is a social scientist in nursing. Megan Davies is an associate professor in the Department of Social Science at York University.**

Our cluster is intended to mobilize and facilitate York research that examines mental health using critical theoretical approaches and social justice

paradigms. Working in conjunction with and in support of the Madness Canada/Folie Canada website and its associated projects, the cluster privileges perspectives of people with lived experience of mental health services, user advocacy and activism, and holistic forms of support that mobilize an intersectional analysis. In this spirit, in February 2020, we held our inaugural *Dialogue, Research, Inquiry, Action: Critical Perspectives on Mental Health/Mad Studies Cluster* meeting. That meeting brought together more than 40 participants from across the York

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# Critical Perspectives on Mental Health/Mad Studies

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### EDITOR

Gabrielle Slowey,  
Director, 2015-2021  
Robarts Centre for Canadian Studies,  
York University

### GUEST EDITORS

Marina Morrow, *Health Policy and Management*  
Cindy Jiang, *Graduate Student, Critical Disability Studies*  
Simon Adam, *School of Nursing*  
Megan Davies, *Health and Society*

### MANAGING EDITOR

Laura Taman, *Coordinator*  
Robarts Centre for Canadian Studies,  
York University

### COLUMNISTS IN THIS ISSUE

Simon Adam	Marina Morrow
Megan Davies	Danielle Landry
Efrat Gold	Sarah Redikopp
Cindy Jiang	Jarret Robert Rose
Abe Joseph	Michelle Sraha-Yeboah

### PRODUCTION

ReWords Editorial & Production Services

### CONTACT FOR INFORMATION

Canada Watch  
7th Floor, Kaneff Tower  
4700 Keele St., Toronto, Ontario M3J 1P3  
Phone 416-736-5499, Fax 416-650-8069  
<http://robarts.info.yorku.ca>

For information regarding future issues, contact Laura Taman, Coordinator, Robarts Centre.

Please address comments to Gabrielle Slowey, Director, Robarts Centre for Canadian Studies.

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community to listen to ten short research talks and engage in a dialogue on a range of topics. It also gave us time to discuss how best to use the cluster to advance research and knowledge mobilization on critical mental health and Mad Studies. During this meeting there was strong support for showcasing the work of cluster researchers in the Robarts Centre for Canadian Studies publication *Canada Watch*.

This issue of *Canada Watch* comes together at an unprecedented time. We are in the midst of a worldwide coronavirus pandemic, and discussions about mental health have been on the public and political agenda in ways not seen before. Predictably, many of the conversations circulating and the government resources committed to address increased mental distress (that is, online platforms for support) have served to reinscribe individualistic and biomedical understandings of mental health (e.g., Flanagan, 2020). However, there has also been some state recognition that the pandemic is disproportionately impacting the mental health of women, Black, Indigenous, and people of colour communities (e.g., Prime Minister's Office, 2020). The pandemic has also spawned a surge of innovations in supports and services that are due in large part to the ingenious work of community-based mental health service providers and those that provide supports to homeless people. If the pandemic has taught us anything, it is that existing social and structural inequities as experienced through racism, poverty, sexism, heterosexism, ageism, and ableism have shaped people's experiences with the virus, the economic impact of the pandemic, and the accompanying mental health stresses.

This societal recognition of mental health has arguably helped to reduce the stigma associated with mental distress. However, it has done very little to shift the paradigm away from understanding mental distress through the lens of biomedicine and the psychological sciences, or to create policies and resources to help address the many



Inaugural meeting of the research cluster on Critical Perspectives on Mental Health/Mad Studies, York University, February 2020.

social and contextual factors that impact mental well-being. This is despite the fact that for generations now people with lived experience and their allies have been actively resisting simplistic understandings of mental well-being and have challenged the domination of psychiatry and the pharmaceutical industry in mental health (Breggin, 2008; Burstow, 2015; Fabris, 2011; Healy, 2012; Whitaker, 2002). The rich history of the psychiatric survivor movement in Canada is one exemplar—psychiatric survivors have told their stories of trauma and abuse within Canadian mental health institutions and at the hands of the psychological helping professions (Capponi, 1992, 2003; Shimrat, 1997); have staged Mad Pride events and conferences to reclaim mad identities and expose society's sanist practices; and have lobbied the Canadian government to review its legal practices that allow for mandatory detention and treatment (Crawford et al., 2019). Indeed, Mad Studies is now an established area of activism, scholarship, and teaching (see, e.g., LeFrançois et al., 2013; Burstow et al., 2014; Daley et al., 2019; Snyder et al., 2019).

Mad Studies overlaps and intersects with the work of critical mental health scholars. These scholars are diverse

and come from a wide range of disciplines, but at the heart of their work is the questioning of psychiatric power and its manifestations in service provision and associated professions (psychology, nursing, social work) (Morrow & Halinka Malcoe, 2017). Critical mental health studies such as Mad Studies work to unseat biomedical dominance in mental health with the goal of social justice.

In this issue of *Canada Watch* we feature scholars who utilize critical mental health and Mad Studies frameworks alongside critical social theory, feminist, and intersectional approaches to explore a range of themes. These include the ways in which psychiatric power operates through structural forms of oppression such as sexism, racism, heterosexism, poverty, ableism, and sanism and how it may be resisted; new frameworks and community-based practices that foster equity and social justice in mental health; and the importance of Mad scholarship and grounding research, practice, and policy in lived experiences.

In "Human Rights and Equity in Mental Health Services," Morrow explores governmental silences regarding human

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rights abuses and discriminatory practices that are both overtly (through mental health laws and policies) and tacitly (through day-to-day practices in mental health) supported and overlooked on a routine basis. Her article holds out hope for more organized resistance and community-based initiatives that are led by people with lived experience and that work to eliminate coercive practices.

In "Demedicalizing Mental Health: Toward Community-Based Approaches," Adam provides us with an overview of his research, which explores the implications of medicalization of mental health using a range of critical theorists as a way to reimagine nursing care. In detailing the consequences of biomedical psychiatric hegemony in the health professions, he inspires a move toward psychiatric abolition and community-based alternatives to psychiatry.

Following on the theme of biomedical dominance in mental health, Joseph in "Psychiatric Power and the ADHD Experience" uses the example of the diagnosis of ADHD (attention deficit hyperactivity disorder) to uncover the ways in which psychiatric power operates to shape the conceptualization, diagnosis, and treatment of mental distress. By centring an analysis of power and its many dimensions, Joseph's work advocates for similar analyses to be applied to other important areas in public health to unearth the ways in which power shapes policy and practice.

In "Constructing Psychiatric Certainty," Gold traces the emergence of biological psychiatry in the era following the Second World War in Canada and how psychiatry, despite a lack of concrete evidence for its theories and practices, came to carry such strong scientific and medical legitimacy. This historical examination sheds light on current trends in psychiatric sciences and challenges us to unseat psychiatric certainty in favour of more relational and non-pathological approaches to mental distress.

In "Mapping a Black Feminist Psychology Framework: Charting Courses

**This societal recognition of mental health ... has done very little to shift the paradigm away from understanding mental distress through the lens of biomedicine and the psychological sciences, or to create policies and resources to help address the many social and contextual factors that impact mental well-being.**

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to Care," Sraha-Yeboah follows on the renewed discussions of anti-Black racism and the dire consequences of police violence for Black communities, often in the context of responding to mental distress calls. Foregrounding the impact of anti-Black racism on mental health, Sraha-Yeboah notes that patterns of help-seeking in Black communities are poorly understood owing to a lack of acknowledgment of the profound impact of racism, psychology's colonial history, and Black cultural practices on well-being and health care preferences. Sraha-Yeboah offers a Black feminist psychology (BFP) framework as a means of advancing culturally appropriate mental health supports in Black communities.

Landry's Mad archival work, "In the Business of Changing Lives': Examining the Activist Knowledge-Practices of Consumer Businesses," seeks to better understand how psychiatric survivor activist knowledges are mobilized for change in the context of businesses run by consumers/survivors. Using archival data and interviews, her research seeks to uncover important local (Ontario) activist histories and to honour the work of Mad activists to ensure that these histories do not go undocumented and can be made accessible to Mad communities.

In "I've Disclosed, Now What? Exploring How Racialized Women with Invisible Disabilities Navigate Stigma and Disclosure in the Workplace," Jiang grounds her work in the concept of "nothing about us

without us," wherein lived experiences are used to provide insight into what it is like to navigate disability disclosures in the workplace. Jiang's work illustrates the intersectional nature of multiple social positions and how power operates to silence racialized women with invisible disabilities. Her work is meant to better inform equity, diversity, and inclusion policies and practices.

In "Depathologizing Self-Harm: The Politics of Survival," Redikopp uses feminism, critical mental health, and Mad Studies frameworks to reconceptualize self-harm as an act of survival. Exploring the gendered and racialized dimensions of distress, her account of self-harm stands in contrast to pathologizing biomedical framings, which often problematically position self-harmers as manipulative attention seekers. Rather than understanding self-harm as a symptom of illness to be dealt with through psychiatric intervention, Redikopp posits that self-harm must be understood in its broader social and economic context as resulting from structural violence and, as such, requires political solutions.

In "Decolonizing Western Psychedelic Consciousness: The Therapeutic and Social Implications of Indigenous Plant Medicine Knowledge," Rose explores the renaissance in the use of psychedelics in mental health as a form of treatment and the current interest in incorporating



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psychedelics into Western psychiatric practice. Rose reminds us that the deep knowledge of psychedelics and psychedelic consciousness comes to Western practitioners through Indigenous healing practices, and he cautions against knowledge appropriation. He advocates a deep respect for Indigenous healing traditions, reflection, and humility on the part of Western mental health practitioners. Ultimately, Rose argues, any use of psychedelics in the Western context must be approached cautiously with a recognition that treatments are embedded in larger historical, social, and cultural contexts.

Collectively, these works represent some of the exciting Canadian scholarship emerging in critical mental health and Mad Studies that is shaping the ways in which we think about psychiatric biomedical dominance and posing viable social justice-oriented alternatives. In the wake of the pandemic, now is the moment to bring these alternative perspectives from the margins to the mainstream. Burgeoning enrolments in Mad Studies and Mad history courses and the strong presence of graduate students in this issue attests to a wide interest in approaches to mental health that go beyond biomedicine. This issue of *Canada Watch* marks a strong beginning from the Critical Perspectives on Mental Health/Mad Studies cluster. 🍁

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on facilitating research has proved to be an effective strategy for breaking down research(er) silos and fostering productive research collaborations.

Critical Perspectives on Mental Health/Mad Studies is an example of a new research cluster that fulfills the centre's mandate to tackle issues that are important to Canadians and Canada. As the country—and, we hope, the world—emerges from a period of COVID-19 lockdowns, conversations about mental health have risen to the surface and make this issue of *Canada Watch* so very

timely. Indeed, the first meeting of the cluster occurred just one month before the first national lockdown was instituted, and the topics covered reflect the researchers' thoughts at the time. It is exciting to see the cluster collect the scholarship presented at its first meeting into this issue of *Canada Watch*, and it is our hope that future issues will similarly showcase the work of other research clusters.

For more on the other nine research clusters housed at Robarts, including the History of Indigenous Peoples Network,

Women and Inclusivity in Sustainable Energy Research Network [WISER], and the Groupe de recherche sur le Canada francophone, Canada francophile et les Études sur Canada en français, go to [robarts.info.yorku.ca/research-clusters/](http://robarts.info.yorku.ca/research-clusters/).

With that, I wish you all happy reading as you peruse this latest issue of *Canada Watch*. 🍁

# Human rights and equity in mental health services

Evidence abounds of the discrimination, stigma, and human rights violations experienced by people who access mental health care, and yet the system's response to this evidence has been poor. Rights violations and coercive practices in mental health care are evident in discriminatory behaviours, stigmatizing attitudes, and the implementation of mental health laws (Brophy et al., 2018; Newton-Howes & Ryan, 2017; Newton-Howes, 2019; Pūras, 2017). The *Canadian Charter of Rights and Freedoms* upholds the right to life, liberty, and security, and is meant to protect Canadians from cruel and unusual punishment (1982, s. 7). Canada is also a signatory to the *UN Convention on the Rights of People with Disabilities* (UNCRPD), and yet many of the routine practices in mental health care violate both the Charter and the Convention (Pūras, 2017, 2018). These practices exist despite a global push toward recovery and human rights-oriented paradigms in mental health (Mental Health Commission of Canada [MHCC], 2009, 2012; World Health Organization [WHO], n.d.). This article provides an overview of these tensions and the current silences surrounding human rights in the Canadian mental health policy context, and highlights examples of resistive strategies and community-based initiatives that give primacy to people's lived experiences.

## MENTAL HEALTH, HUMAN RIGHTS, AND SOCIAL JUSTICE

The Canadian mental health care system has often been referred to as a two-tiered system, or as one of “the orphan children” of medicare (Romanow, 2002, p. 178). From the inception of medicare, key players like the Canadian Mental Health Association (CMHA) and, indeed, Tommy Douglas himself supported the idea that medicare should include coverage for mental health. Regrettably, political jockeying ultimately resulted in medicare covering only

BY MARINA MORROW



**Marina Morrow is a professor at the School of Health Policy and Management in the Faculty of Health at York University. She uses critical mental health and intersectional approaches in her work to better understand the social, political, and institutional processes through which health and mental health policies and practices are developed and how social and health inequities are sustained or attenuated for different populations. Marina strongly supports public scholarship and the work and activism of the Mad movement and Mad scholars. Marina is the lead editor (with Dr. Halinka Malcoe) of *Critical Inquiries for Social Justice in Mental Health* (University of Toronto Press, 2017).**

medicalized services, including psychiatry, and, in the case of severe illness, a variety of community-based support systems that remain difficult to access and that by all accounts are fragmented and poorly coordinated (Marchildon, 2011; Kirby & Keon, 2006; Flood & Thomas, 2017). Meanwhile, those with money can access private psychological services and a range of mental health supporting resources like housing, good nutrition, access to recreation, and other wellness-related goods. This funding arrangement means that mental health is primarily defined in medical terms, a fact that structurally and ideologically limits the ability of governments to respond to the wide range of social needs that undermine mental well-being. Effectively, the Canadian mental health care system sees the social and structural determinants of

mental health as secondary to the biological and genetic causes of mental distress, despite there being little scientific evidence to support this unidimensional understanding of mental health (Malla et al., 2015).

Human rights abuses and coercion arise from an entrenched belief that people suffering from mental illness and distress (especially as manifested in psychosis or forms of socially unacceptable behaviour) are incapable of making decisions about their needs. That is, people suffering from mental illness and distress are assumed to lack insight into their own condition, and therefore the state must step in to constrain and treat them. While most would acknowledge that there are situations in which people may pose a risk of harm to themselves or others, the current method of constraining and forcibly treating people is a blunt instrument for dealing with a complex and nuanced human problem. Mental health laws that allow for committal and forced treatment function through the mechanism of mandatory detention (Reilly et al., 2018). Compliance with mandatory detention and subsequent treatment is often enforced through interdisciplinary mental health care teams in coordination with police. The grounds on which mandatory detention orders can be issued vary from region to region, but orders are generally based on risk assessments of harm “to self or others.” While it is recognized that domestic mental health laws operate in contravention of the UNCRPD<sup>1</sup> (Pūras, 2017, 2018; Hoffman et al., 2016), there has been little political will to bring domestic laws in line with international law.

Besides mandatory detention orders, other potentially damaging practices continue to proliferate, including the use of seclusion and restraints in hospitals, electroconvulsive therapy (ECT), and

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stigma and discrimination that result in real harms and deter access to supports (Brophy et al., 2016; Milne & Williams, 2000). Discrimination based on gender, racialization, citizenship, and colonization interacts with mental illness, and thus certain populations are disproportionately impacted by these practices and by mental health human rights violations (Halinka Malcoe & Morrow, 2017). For example, men who are racialized, migrant, and Indigenous are more likely to be issued mandatory detention orders (Van Veen et al., 2018) and to be subject to coercive practices such as isolation rooms and physical and chemical restraints (Singh et al., 2007). Treatments that have proved damaging to the brain such as ECT are used more frequently on older women (Milne & Williams, 2000).

## EXPLORING TENSIONS AND SILENCES

Countering discrimination and human rights violations in mental health care is the ongoing quest for more just and equitable mental health services both in Canada and internationally (Friedli, 2009; WHO, n.d.). Sweeping Canadian mental health care reforms since the 1960s have shifted the focus from institutional care to the provision of care in the community and have shifted the care paradigm from a custodial model to a model in which care is user-driven and enacts the recovery principles of autonomy and choice (MHCC, 2009, 2012; Mulvale et al., 2007). Recovery as a philosophy of care is rooted both in the activism of people with lived experiences of psychiatric institutionalization (e.g., Deegan, 1988) and in professional practice (Cleary & Dowling, 2009; Davidson et al., 2011). Recovery posits that, regardless of people's limitations due to illness, all people can live meaningful lives if they are free from stigma and discrimination and are able to access care and supports that foster self-determination (MHCC, 2012; Onken et al., 2007). Moreover, the recovery movement calls attention to the larger social and systemic issues facing


people, including discrimination and the need for economic security (see Jacobson & Farah, 2012; O'Hagan, 2004).

Arguably, neoliberal policy and discursive regimes have co-opted recovery, reducing it from a powerful psychiatric survivor political movement to an individualistic approach that largely ignores the social and structural factors that impact people's lives (Morrow, 2013; Morrow & Weisser, 2012). Dramatic cuts to the social welfare state and the entrenchment of reductionist business models in mental health services have meant that discussions of rights and discrimination are largely absent in Canadian mental health policy. Indeed, in a climate of scarcity of supports, the loss of rights is often silently taken for granted as a prerequisite for accessing mental health care.

While the tensions between care and control as manifested in services have been much remarked on (e.g., Morrow et al., 2008), little progress has been made in reconciling these tensions, and indeed current policy responses trend toward social control. For example, the increasingly widespread integration of police into mental health care is resulting in new forms of surveillance and containment (Van Veen et al., 2018).

## COUNTERNARRATIVES AND RESISTIVE PRACTICES

Activists have raised concerns about forced treatment, isolation, and restraints since the early days of deinstitutionalization, often using first-person narratives of the impact of these experiences (Shimrit, 1997; Capponi, 1992, 2003). Community-based organizations that are led or informed by psychiatric survivors are also sites of resistance, offering models of support that are non-medical and non-coercive and educating people about their rights (e.g., the Gerstein Crisis Centre in Toronto and the West Coast Mental Health Network in Vancouver). Activists have also challenged the Canadian government to bring its domestic mental health laws into full compliance with the UNCRPD (Crawford et al., 2019) and have

launched lawsuits against provincial mental health statutes (e.g., Council of Canadians with Disabilities, 2016). Researcher partnerships that give primacy to the knowledge and experience of psychiatric survivors are also playing a role in building an evidence base that supports equity and human-rights-informed care (Morrow et al., 2020). While resistance is strong, it is not well coordinated, and supports are needed to sustain concerted pressure on the Canadian government to recognize the depth of the harms caused by services that violate human rights and basic human dignity. 

## NOTES

1. When Canada ratified the UNCRPD in 2010, it reserved the right to retain substitute decision making, which allows for detainment under provincial mental health statutes.

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# Demedicalizing mental health: Toward community-based approaches

## PROMOTING COMMUNITY-BASED APPROACHES TO MENTAL HEALTH CARE

My research generally addresses the following question: *What are the implications of the medicalization of mental health on the well-being of marginalized communities, and how can community-based approaches to mental health care be promoted?* Substantively, my research informs the nursing discipline and reports on the nature of “mental illness” using critical theory. That is, it engages with a sociological deconstruction of the concept of mental illness/health by way of examining power and discourse within the nursing discipline. My research is informed by critical theory and post-foundational thought and draws on the work of such philosophers as Michel Foucault, Gilles Deleuze, and Rosi Braidotti in the investigation of mental illness and mental health. Being informed also by survivor narratives and perspectives, my research can be described as a grassroots approach to knowledge development in mental health discourse. My research approaches include critical qualitative methods—namely, ethnographic approaches (institutional ethnography, critical ethnography, rapid ethnography)—as well as critical phenomenology and critical discourse analysis.

Having established that mental health nursing is institutionally and discursively colonized by biomedical psychiatry (Adam, 2017; Adam & Juergensen, 2019), the overall goal of my work is to work toward the demedicalization of mental health nursing discourse (and, eventually, the cognate health profession discourses) from biomedical psychiatric hegemony. I am currently undertaking three interlinked projects as I work toward this goal.

### THREE PROJECTS

Working with local community mental health agencies, I have designed a community-based research project, framed

BY SIMON ADAM



**Simon Adam is a social scientist in nursing. His program of scholarship focuses on the mental health industry, its institutional and discursive dimensions, the consumer/survivor/mad experience, and alternative and counterhegemonic ways of conceptualizing human illness, suffering, and crisis. His work considers what is currently termed “mental illness” as being largely a product of social, economic, and political apparatuses, and examines how education, professionalization, and pop culture reproduce a medicalized understanding of an otherwise normal human condition. Simon works with various communities, including psychiatric survivors and psychiatric consumers, mad people, neurodiverse people, and people who use drugs. In addition to scholarly venues, his work also appears on his podcast, *Crazy Making*, at [anchor.fm/crazymaking](https://anchor.fm/crazymaking).**

by a critical methodology known as political activist ethnography. In this project, psychiatric survivors are central, as they inform the trajectory of the research by engaging in an institutional analysis of psychiatric education and critical discourse analysis of nursing mental health texts. Participant survivors with the researcher engage in the critical examination of institutional texts to help surface problems reproduced by psychiatric discourse. The activism involves the interrogation and exposure of the psychiatric hegemony in these institutional texts and processes, which drives further data collection, which in turn fuels the activism. The project aims to centre survivor

perspectives in the development of mental health nursing education in Canada while simultaneously empowering survivors with the position of critiquing dominant texts and institutional discourse that give rise to psychiatric oppression.

The second project critically examines mental health discourse from the standpoint of women diagnosed with postpartum depression. In this work, which began in response to peculiar discursive shifts related to postpartum depression in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), I examine the constructions of the “disorder” in current literature, including the construction that played a central role in the development of its latest conceptualization in the DSM-5 (American Psychiatric Association, 2013). Having established that phenomenological accounts of postpartum depression do not take into consideration any critical orientations toward the discursive formation of the disorder, my colleagues and I discovered that critical mental health and Mad perspectives are absent from discussions of postpartum depression (Johnson et al., 2020). There is thus a glaring gap in the discourse on the topic, particularly the lived experience of women who do not necessarily accept postpartum depression as a medical condition. I am currently engaged in research soliciting this perspective and undertaking a critical institutional analysis of its absence from mainstream postpartum depression discourse.

In my third project, working with an interdisciplinary team of researchers and professionals (paramedics, social workers, police), I am investigating models of mental health care in the acute care sector. Specifically, this project critically examines current models of mental health crisis responses in Ontario and proposes more humane and supportive responses than those offered under the

# Demedicalizing mental health continued from page 9

nurse/social worker/police officer model (Toronto Neighbourhood Centres, 2021). Given the notable increase in police brutality and violence, which has especially affected marginalized groups and those with mental health issues, this project is not only timely but also a necessary activist response to the call to abolish carceral and punitive forms of justice.

The consequences of biomedical psychiatric hegemony in the health professions are both far-reaching and highly problematic for society. The reproduction of biomedical psychiatry through the cognate disciplines will continue to lead to violent and, at best, highly problematic practices aimed at “helping” while often producing the very opposite result. While the current evidence of the profuse medicalization of mental health in nursing education is rather clear (Adam, 2017; Adam et al., 2019; Adam & Juergensen, 2019), my hope is that the contributions of these projects, and my work more generally, will fuel the global psy-

chiatric abolitionist movement and help to create more community-based alternatives to psychiatry. 🍁

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# Psychiatric power and the ADHD experience

In my adult life I have found counseling to be a useful tool for understanding my past in order to help me to shape my future. In October 2019, my counsellor recommended that it might be helpful if I were assessed for attention deficit hyperactivity disorder (ADHD). She suggested that the challenges that I was facing in navigating work, social, school, and romantic spaces could be a result of having ADHD. Coincidentally or not, at the time I was working toward completing my master's degree, which focused on the role of psychiatric power in ADHD.

Having struggled with attention and focus most of my life, I was not terribly shocked by my counsellor's suggestion. However, when she asserted that ADHD was a genetic disorder often passed down matrilineally, I was caught off guard, for two reasons. First, I have yet to find research that definitively supports this claim, and second, there is a significant body of research that says otherwise. There is a continued, consistent absence of research showing clear biological causal links between genes and ADHD (Timimi, 2017).

However, my counsellor's understanding of ADHD reflects the dominant biomedical thinking and decades of research that aims to claim that ADHD is a genetic disorder. This line of research has played a large role in the development and legitimization of ADHD care that prioritizes behavioural diagnostic criteria alongside pharmaceutical treatment.

## WHY HAS THIS BIOMEDICAL VIEW OF ADHD CONTINUED TO DOMINATE?

The question then is, *Why has this biomedical view of ADHD continued to dominate?* I propose that answers to this question lie in better understanding the ways in which power shapes ADHD conceptualization, diagnosis, and treatment.

Attempts to improve population health through public health policy do

BY ABRAHAM JOSEPH



**Abraham Joseph completed his Master of Arts (MA) in health policy and equity at York University in June 2020 and is now a doctoral student in the same program. His research explores intersections of power and mental health policy. He is interested in the ways in which power dynamics influence our ability to live safe, healthy (physically, mentally, socially), fulfilling, and meaningful lives.**

not usually feature the concept of power as central to the discussion. ADHD and other mental health discussions are no different. Policy in this area generally disregards the role that societal power structures play in determining individual behaviours. As an alternative to much of this ADHD policy research, my research focuses on power. This is important because power dynamics play a central role in influencing how we think about ADHD support in mental health care and, therefore, how we decide to design our health care systems and policies to meet the needs of those experiencing ADHD symptomatology.

In order to situate power at the centre of my analysis, I adapted the framework developed by Pulker et al. (2018) that illuminates the ways in which supermarkets hold power within the Australian food system. Pulker et al.'s framework explores how supermarkets have obtained, from various sources, power that functions across four areas of influence: instrumental power, structural

power, discursive power, and political legitimacy. Each dimension of power overlaps with and reinforces the others. My adaptation of this framework (see figure 1) relates psychiatric power to the ADHD diagnosis rather than supermarket power to the food system.

The dimensions of power (instrumental, structural, discursive, and political legitimacy) retain their conceptual meaning in the adapted version of the framework. For each numbered example of supermarket power in the original framework, analogous categories in the adapted version are identified.

In the adapted framework, *instrumental power* is represented by the direct influence that psychiatrists have over the decisions of others, such as patients, caregivers, health care professionals, educators, and people like my counsellor. *Structural power* is embodied by agenda setting and rule making that limit an individual's range of choices. *Discursive power* is represented by messaging that influences societal norms and values related to ADHD. Lastly, *political legitimacy* functions mainly to give authority to the other forms of power.

## ADAPTING THE POWER FRAMEWORK

Adapting the power framework was a process of creation and discovery. As I filled in the categories of psychiatric power to create the adapted power framework, my understanding of psychiatry's influence on the ADHD experience became clearer. Psychiatry plays a central role in influencing the dominant ways in which ADHD is conceptualized, diagnosed, and treated.

In terms of instrumental power, this process highlighted the coercive nature of surveillance carried out by teachers, administrators, and medical professionals in the name of medical treatment and support. Children experiencing ADHD

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symptomology seek out professional support to help them to better navigate their lives across domains (social, educational, familial, environmental) that are often quite challenging for them. One might think that the central aim of mental health support is to empower these children so that they are better equipped to be successful in their everyday lives. However, a tension arises when a child diagnosed with ADHD questions the “need” for medication, eliciting the psychiatric labels of “problematic” and “non-compliant.” The irony here is that the very development of agency around personal care and mental health is what provokes psychiatric responses that are disempowering and dismissive. This tension uncov-

ers the coercive nature of biomedical treatment plans common in ADHD care.

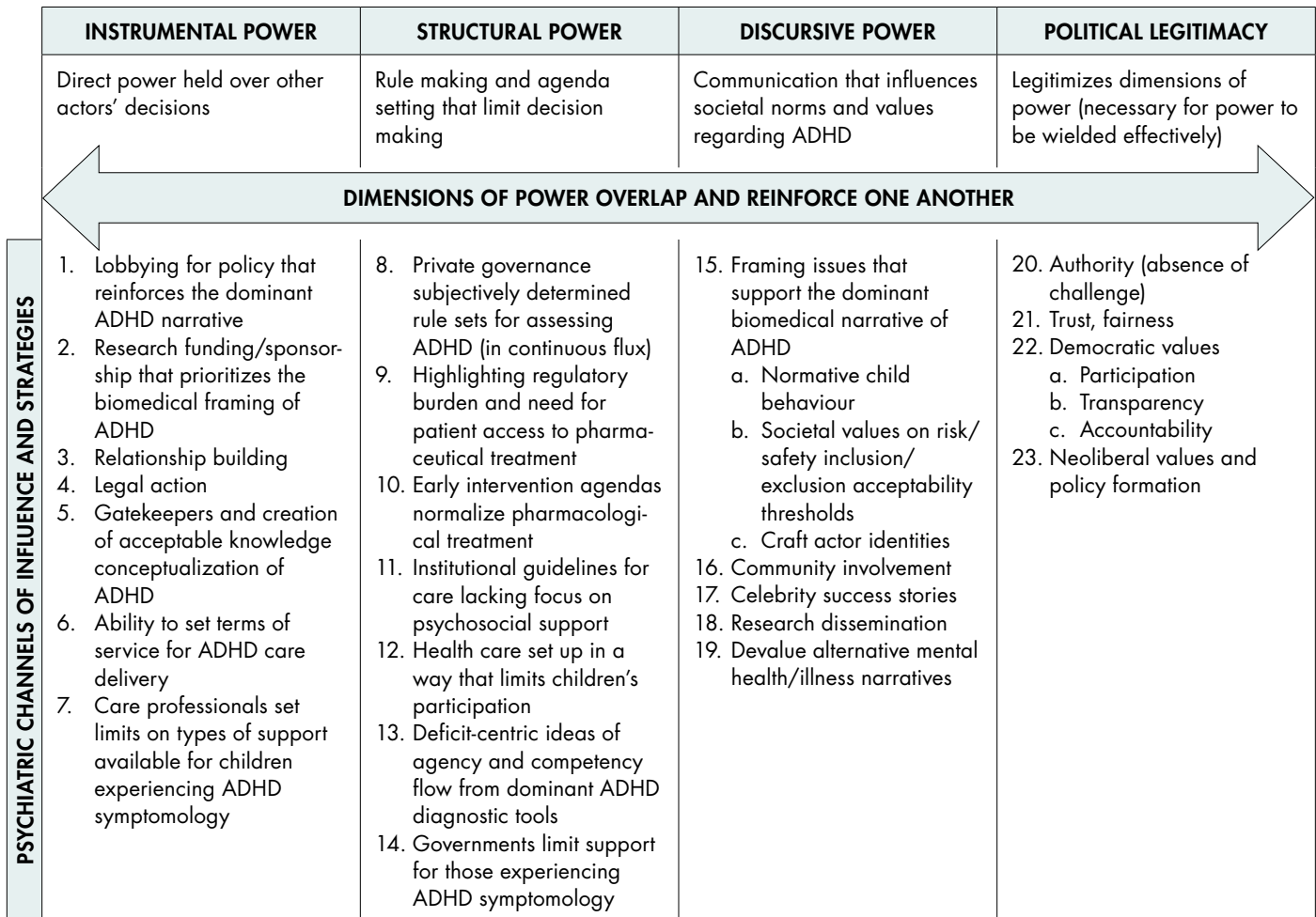
Structural and discursive psychiatric power shape the ADHD experience in less direct ways, by influencing the rules for diagnosis and treatment and creating and controlling notions of acceptable and unacceptable behaviour. One of the main ways this plays out is within the context of Canadian education systems, where the focus is often on fixing or controlling children’s “unacceptable” individual behaviours. These are ultimately subjective, decontextualized determinations, and will be somewhat different from teacher to teacher.

The framework of the dimensions of power highlights access points for

good social policy that could go a long way toward facilitating more supportive school and home environments. The creation of social policies that increase funding to education and reduce the material burden, such as guaranteed housing and health care that is truly universal and includes dental and psychological supports, would help relieve stress on individuals throughout society. This is important because when good supportive social policies are instituted, practitioners and parents are subsequently less overwhelmed, and teachers have smaller class sizes and are therefore able to spend more time being creative with their lessons and attuning to their students’ needs in a more responsive way.

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**FIGURE 1 Framework of the Dimensions of Psychiatric Power and Influence**



Source: Adapted from Pulker, C.E., Trapp, G.S.A., Scott, J.A., & Pollard, C.M. (2018). What are the position and power of supermarkets in the Australian food system, and the implications for public health? A systematic scoping review: Scoping review of supermarket power. *Obesity Reviews*, 19(2), 198–218.



# Constructing psychiatric certainty

BY EFRAT GOLD



**Efrat Gold is a PhD candidate at the University of Toronto engaging in Mad and Disability Studies. Through her writing and activism, she challenges dominant views of mental health and illness, moving toward contextualized and relational understandings of well-being. Gold critiques psychiatry, focusing on those most vulnerable and marginalized by psychiatric power, discourse, and treatments. Her work is staunchly feminist, anti-racist, and anti-oppressive. Through explorations into meaning-making and constructions of legitimacy, Gold unsettles psychiatric hegemony by “returning to the sites where certainty has been produced.”**

My dissertation research returns to the era following the Second World War in Canada, when biological psychiatry began to carry the weight of medical certainty. In exploring this history and challenging psychiatric legitimacy, I take up the concept of what Canadian Disability Studies scholar Tanya Titchkosky (2011) calls “a restless reflexive return to what has come before,” which “requires us to be restless with the concept of certainty by returning to its production and not permitting it to remain unquestionably certain” (p. 15). In revisiting the era when psychiatry became perceived as having scientific and medical legitimacy, I enact a restless return to the concept of psychiatric certainty. In doing so, I ask: *Where did this era of psychiatric legitimacy come from? And how does it fit into larger historical trajectories of ascribing meaning to human difference, struggle, and suffering?*

## PSYCHIATRIC DISORDER AS SCIENTIFIC FACT

Psychiatric disorders are often understood to be scientific fact—as established as any physical disease. However, unlike in other branches of medicine, psychiatric diagnoses are made on the basis of a person’s behaviour, or feelings of distress, and generally preclude medical and scientific testing. In other words, the precursor to receiving a psychiatric diagnosis is being *distressing*, either to oneself or to others. The diagnostic criteria that this distress is measured against consider such factors as a person’s ability or willingness to work and socialize in ways considered “normal.” In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), these criteria are expressed in language that defines supposed psychiatric symptoms as causally interfering in a person’s “social or occupational functioning” (American Psychiatric Association, 2013). As a branch of medicine, psychiatry represents a medicalized approach to treating human distress, lack of productivity, or other types of suf-

fering. The underlying premise—that those given psychiatric diagnoses have a *biological or genetic cause* behind their disorder—relies on unproven theories of genetic heredity and predisposition. And yet, without testing, psychiatric diagnoses largely hinge on a person’s social or occupational functioning—factors that speak to a person’s ability to cope only within current Western ideations of productivity and sociality (Taylor & Gold, 2019; Cohen, 2016).

The legitimacy bestowed upon psychiatry is not, nor has it ever been, based on whether or not psychiatric methods work. Contemporary psychiatry speaks to the context out of which it arises more than it does to any stand-alone objective scientific or medical *fact*. Unlike in other branches of medicine, definitions of psychiatric disorders rely heavily on relational norms—for example, whether a person can work and socialize appropriately, whether they can behave in line with societal standards, and whether a

lack of behavioural adjustments to societal standards interferes with their daily functioning. These examples suggest that people who are not adjusted to cultural norms are classified as mentally ill, providing relational definitions for phenomena that are mostly assumed and presented as having a biological basis. Contemporary psychiatric diagnoses speak to capitalist ideals of productivity, according to which being unproductive is the defining factor of being mentally ill; these disorders are constructed into existence through the use of norms. To quote Canadian anti-psychiatry scholar Bonnie Burstow (2015):

The fact that this is an institution that operates on conjecture and declaration rather than on proof, an institution that not just occasionally but routinely calls things diseases in the absence of observable physical markers, I would add, raises the question whether we are truly dealing with medicine here, at least in the modern sense of the term. Indeed, it raises the question of whether we are dealing with science at all. (pp. 13–14)

## BIOLOGICAL PSYCHIATRY IN CANADA

In Canada, biological psychiatry, loosely defined as “the search for physiological, genetic and chemical bases” for psychiatric disorders (Kirk & Kutchins, 1992, p. 10), gained traction following the Second World War. As traumatized veterans and European refugees tried to recover their lives, and as militaries around the world took interest in the potential of the psy-disciplines (psychiatry, psychology, and psychiatric social work) to change and/or control human behaviour, these new frontiers created interest and investment to explore the potentials of psychiatry (Gold, 2016). However, the goals of changing and controlling human behaviour were not new and speak to the cultural origins of biological psychiatry,

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which lie in ideologies of eugenics and mental hygiene.

During the eugenics era (from the late 1800s to the mid-1900s), social constructions of deviance and undesirability became framed in terms of genetic heredity. This led to social and economic policies that characterized marginalized groups as needing to be removed from society in order to preserve its integrity. Theories of genetic superiority and inferiority were utilized to justify conceptualizations of Indigenous people, Jews, queers, the mad and disabled, those in poverty, the so-called feeble-minded, and other undesirables as “parasites,” “useless eaters,” “life not worthy of living,” and those needing to be “weeded out” to protect the morality of society (Kevles, 1985; Russell, 1998). The eugenics era culminated in the Holocaust, which encompassed the killing of millions.

Following the end of the Second World War, eugenics was no longer widely seen as progressive; instead, it was robustly condemned as a dangerous, racist, and outdated ideology that had led to a terrifying episode of human depravity. However, the theories underlying eugenics did not simply disappear, but came to be reconstituted in new ways. Biological psychiatry continues to aggressively pursue theories that promote hereditary and neurological etiology underlying so-called mental illnesses (Burstow, 2015). One limitation of theories that assume genetic, chemical, or hereditary causes for behaviours and feelings is that they miss the role of context, oppression, agency, and, importantly, the connectedness between people and the social reality in which they are embedded.

## IGNORING THE RELATIONSHIP BETWEEN BIOLOGY AND SOCIAL EMBEDDEDNESS

A medicalized approach to human suffering ignores the complex and multifaceted relationship between biology and social embeddedness. In the case of the chemical imbalance hypothesis, it

The legitimacy bestowed upon psychiatry is not, nor has it ever been, based on whether or not psychiatric methods work. Contemporary psychiatry speaks to the context out of which it arises more than it does to any stand-alone objective scientific or medical fact.

is theorized that mental illness is *caused* by an imbalance of neurotransmitters such as dopamine and serotonin, the levels of which are not generally tested prior to a psychiatric diagnosis. In theory, treatment with psychiatric drugs should restore the balance of these neurotransmitters, and in doing so should *fix* or *eliminate* the psychiatric disorder. While it seems to be true that there is a relationship between neurotransmitters and affect, correlation does not equal causation. Within psychiatric frameworks, efforts are not made to integrate complex knowledge of the relationship between neurotransmitters and the material conditions of a person’s world beyond basic cause-and-effect. Communities of people who have lived through psychiatric diagnoses and treatments, often referred to as psychiatric survivors, are among the first to call attention to the harms caused by psychiatric involvement. By returning to the sites where psychiatric certainty was constructed, I challenge this certainty and offer non-pathologized, relational approaches to suffering and distress. 🍁

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# Mapping a Black feminist psychology framework: Charting courses to care

In the wake of police violence against Black people and a global health pandemic disproportionately impacting racialized groups, the call for reimagined “care” for Black life reverberates loudly throughout the African Diaspora. The Mental Health Index report by Morneau Shepell (2020) found that Black Canadians’ mental health remains low amid the COVID-19 pandemic. The report also noted a decline in mental health scores for Black Canadians between May and June 2020 that corresponded with the high-profile murder of George Floyd, and the most intense period of awareness and response to anti-Black racism. Our current moment has crystallized the awareness that greater mental health care measures are required to ensure Black Canadians’ well-being. A violent history of colonization, displacement, and dispossession in the transatlantic chattel slave trade and its legacy of anti-Black racism has impacted the Black community’s “equal access to social, economic, political, and cultural resources” (Ottawa Public Health, 2020, p. 5).

## REFRAMING THE FOCUS

We can trace the trajectory of Black Canadians’ historical exclusion from social life more generally, to their exclusion from contemporary mental health care institutions more specifically. Black Canadians’ reported experiences within the mental health care system include discrimination, racism, financial barriers, misdiagnoses, unreasonably long wait times, lack of cultural competency, and limited representation in the mental health care workforce (Ottawa Public Health, 2020). Improving mental health care service delivery for Black Canadians requires an in-depth look into the primary causes of Black Canadians’ mental health care service use disparities. To date, there has been substantial research on the impact of social and physical

BY MICHELLE SRAHA-YEBOAH



**Michelle Sraha-Yeboah is a doctoral candidate at York University in the Department of Social and Political Thought. Her research examines medical histories of racial and colonial violence, mental health care service use disparities, and holistic well-being. Her work is particularly concerned with the intersections of socio-historical and political factors impacting Black Canadians’ mental health care service use patterns and treatment preferences. She attends to Black feminist theorizations of care to achieve anti-racist and decolonial mental health care service delivery for Africans in the Diaspora.**

determinants on utilization and access; however, this exclusive focus has masked the role of a broader set of historical, socio-political relations impacting help-seeking patterns. Reframing the focus for Black Canadians can offer an innovative way forward to advance mental health care service delivery, and curate culturally compatible treatment interventions.

Contributing to the field of Mad Studies, I seek to expand discussions of Black Canadians’ mental health care service use patterns to include theoretical considerations about mental health care within a Black feminist psychology (BFP) framework. I propose a Black feminist psychology framework to examine the interactive relationship between psychology’s colonial history, neoliberalism, and Black cultural practices of well-being with regard to service use patterns and

treatment preferences. The framework builds on the central tenets of critical psychology and Black feminism. Critical psychology seeks to address operations of power, and the field’s lack of reflexivity concerning the socio-historical dimensions of psychology (Teo, 2018). Black feminism explores the socio-historical, political, and cultural conditions of Black life, and generates transformative change in political and economic institutions (Collins, 1990). Together, these frameworks link interdisciplinary methods of engagement and creative bodies of knowledge to effect change in mental health care service delivery. Accordingly, a Black feminist psychology framework can be mobilized to attend to the relationship between power and knowledge production in psychology in order to address underlying colonial dynamics; to challenge neoliberal understandings of mental health that negate the role of structural barriers; and to centre Black feminist perspectives to imagine culturally nuanced mental health care services.

## **HISTORICALLY ATTUNED, POLITICAL ENGAGED, AND CULTURALLY COMPATIBLE MENTAL HEALTH CARE**

A Black feminist psychology framework helps to ensure historically attuned, politically engaged, and culturally compatible mental health care for Black Canadians. It achieves the first objective by bearing witness to the damage caused in the field under the veils of scientific “progress” and “healing” (Howitt & Owusu-Bempah, 1994). The framework situates mainstream psychology within the context of colonial violence, slavery, and racial oppression in order to interrogate the genealogy of compromised mental health care service delivery for Black Canadians. Black feminist psychology

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# Mapping a BFP framework continued from page 15


invites researchers to consider how psychology's ideologies, methodologies, and data analysis have historically served as an instrument of social control and surveillance for its multiracial clients (Jones, 2015). Within this framework, lack of participation in formal mental health programs registers as being inextricably tied to intergenerational experiences with the mental health care system and as a mode of resistance (Burack, 2004). A historical attentiveness creates space to trace patterns of inequality and perform practices of "Black annotation" on the erasures and oversights of Black suffering in the field (Sharpe, 2016, p. 117). Thus, Black feminist psychology views its epistemic responsibility as being to prioritize accountability and transparency in its investigation of Black Canadians' service use patterns and treatment preferences.

Neoliberalism has masked its role in contributing to the pathogenic social-political conditions it has fostered with its market rationality and taxing autonomy (Sugarman, 2015). The emphasis on individualism serves to position mental health challenges as the product of idiosyncratic choices rather than the result of systemic factors. Ultimately, neoliberalism makes mental health challenges the responsibility of individual actors to fix instead of society's obligation to redress (Prilleltensky, 2008). A Black feminist psychology framework highlights the work of political structures and policies to reveal how they condition Black communities' engagement with mental health programs, and governmental responses to Black Canadians' mental health care concerns. The framework's principles reframe psychological help as the promotion of systemic and political change. Establishing less oppressive and exploitative conditions is key to improving Black Canadians' mental health care service delivery. Black feminist psychology aligns itself closely to social justice enterprises by embracing collaboration with grassroots and community-based organizations to foster activism against structural oppression.

## ALTERNATIVE PATHWAYS

A framework that explores service use patterns for Black Canadians must also work to create more culturally informed mental health care initiatives. A Black feminist psychology framework amplifies voices typically silenced or overlooked in formal mental health care settings and foregrounds their experiences. Collapsing value-laden distinctions between "scientific" and "non-scientific" sources, the framework explicitly attends to Black feminist thought. Black feminist creative writers often present ancestral healing as a spiritual and communal enterprise for Black diasporic communities experiencing trauma (Jones, 2016). Their insights remind us that alternative pathways to care should include Indigenous healing traditions as well as alliances with informal mental health service providers traditionally accessed by Black communities (such as religious leaders, clergy, and spiritual counsellors). Faith and spirituality are commonly documented as a protective factor for strong mental health (Ottawa Public Health, 2020), and a Black feminist psychology framework demonstrates renewed efforts to merge theistic considerations within mental health care practice and to consider approaches to mental wellness that have not historically dominated the scholarship but that have socially prevailed in community practice.

An anti-racist and decolonial approach to mental health care for Black Canadians demands a new paradigm that attends to the intersections of historical, political, and colonial forces that perpetuate anti-Blackness in the field, and that seeks to disrupt these conditions to imagine new interventions. A Black feminist psychology framework offers a theoretical mode of inquiry to ensure that Black Canadians' diverse histories, political realities, and unique social experiences are meaningfully addressed in the field. Charting the path toward improved mental health care service delivery must move beyond the shores of academe; it

must make waves in community health care settings, sacred spaces, and government halls to redraw the lines in the sand and build stronger mental health care for Black Canadians. 

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# “In the business of changing lives”: Examining the activist knowledge-practices of consumer businesses

## WHY WOULD A COURIER COMPANY TAKE ACTION TO SUPPORT A CLEANING BUSINESS?

In the summer of 2009, Diana Capponi sat down for a filmed interview with David Reville, then a professor at Ryerson University and a long-time consumer/survivor community organizer. At the time of the interview, Diana was the Employment Works! coordinator at the Centre for Addiction and Mental Health (CAMH). Previously, Diana had co-founded the Ontario Council of Alternative Businesses,<sup>1</sup> an organization representing small businesses run entirely by people who have been diagnosed as and labelled “mentally ill.” Sitting in the sunshine garden at CAMH that summer day, the two old friends spoke at length about mad people and work.<sup>2</sup> During the interview, Diana described a grassroots action taken by workers at a courier company, A-WAY Express, in response to a threat by the Ontario Ministry of Health to revoke some base funding from a business called Fresh Start Cleaning and Maintenance. Both were consumer/survivor businesses that followed a community economic development model, which meant they relied on government funding. They had a shared interest. The funding that was at risk of being withdrawn was essential for providing employment opportunities to consumers/survivors at Fresh Start. In solidarity with Fresh Start, workers at A-WAY Express Couriers responded by spending a full day hand-delivering letters to the minister of health’s office, one every half an hour. Diana laughs as she recounts how the receptionist at the minister’s office grew irritated by the end of day. But that action, in tandem with other complaints and actions coordinated through a psychiatric survivor listserv,

BY DANIELLE LANDRY



**Danielle Landry is a PhD candidate in sociology at York University. Her SSHRC-funded doctoral research focuses on the activist knowledge-practices of psychiatric consumer/survivor businesses in Ontario in the 1990s. Most recently, her work has been published in *Relations industrielles/Industrial Relations, Curriculum Inquiry, Journal of Literary and Cultural Disability Studies, Disability & Society, and Studies in the Education of Adults*. She has taught a variety of in-person, online, and hybrid courses in both Mad Studies and Disability Studies at Ryerson University. She was the 2020 recipient of the Wilhelm Cohnstaedt Social Justice Award.**

was successful in restoring much-needed funding for Fresh Start’s operations.

## WHAT DOES THIS HAVE TO DO WITH MAD STUDIES?

This interview snippet offers one example of mad people expressing a community-based politics of solidarity through their involvement in these businesses. Upon hearing stories such as this, I am struck by three things: (1) how workers in consumer/survivor businesses engaged in activist knowledge-practices during the 1990s; (2) the lack of empirical research, particularly within Mad Studies, focused on consumer/survivor businesses as sites of community organizing; and (3) the risk of losing our activist histories as leaders in the consumer/

survivor/ex-patient (c/s/x) movement such as Diana Capponi pass on. Over the last decade, there have been a handful of studies of consumer/survivor businesses in Ontario (e.g., Buhariwala et al., 2015; Corbiere et al., 2019; Hall & Wilton, 2011; Kidd et al., 2015), but none have considered the kinds of *political* practices described in the narrative above.

As an emerging Mad scholar and a PhD candidate in sociology at York University, I aim in my doctoral research to uncover how consumer/survivor businesses were sites for producing and mobilizing activist knowledges and how those knowledges were significant for their employees and for the c/s/x movement generally. Applying an “ethnographic sensibility” (Schatz, 2009) amid the COVID-19 pandemic, this sociological study draws on archival data and interviews to pose critical questions about activist knowledge-practices within these sites (Casas-Cortés et al., 2008). In doing so, this study aims to contribute to a rethinking of the significance of consumer/survivor businesses, to uncover a piece of our activist history that has not been given its due.

## “IN THE BUSINESS OF CHANGING LIVES”

Distinct from earlier models of vocational rehabilitation, sheltered workshops, or other psychiatric service provider-led programming, consumer/survivor businesses are noteworthy for their egalitarian approach, grassroots origins, and being survivor-led at all levels of the organization. Consumer/survivor businesses are unique to Ontario. They were not created with the primary intent of being therapeutic, or to simply put a few dollars in community members’ pockets (though they do help to sustain a

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# Activist knowledge-practices continued from page 17

few people within the community), so to evaluate them solely on the basis of these criteria overlooks what motivated the establishment of these businesses in the first place. I argue that in order to fully comprehend the establishment of consumer/survivor businesses, we need to understand local c/s/x organizing and history. These businesses emerged during a time of significant change. At the beginning of the 1990s, the c/s/x movement needed to adapt to sustain itself through a recession and, specific to Ontario, under a conservative provincial government. In the early stages, these businesses were a means to an end for c/s/x organizers. Survivor leaders such as the late Diana Capponi, who took it upon themselves to manage and lead these businesses, were in fact “in the business of changing lives” (K. Church, personal communication, 2020). From within these businesses, survivor leaders would rally community members and organize around pressing issues facing their community. For example, one primary concern of the local c/s/x movement during the late 1990s was to fight incoming provincial legislation around community treatment orders (CTOs) (Fabris, 2011).

## MAD ARCHIVAL WORK IS POLITICAL

Studies seeking to evaluate the effectiveness of these businesses either as therapeutic intervention or as social entrepreneurship overlook a significant piece of Mad history. Bridging the sociology of social movements, the sociology of knowledge, and Mad Studies, my research aims to pose critical questions about generating, molding, and mobilizing activist knowledges. Doing so requires thoughtful reflection on the preservation of community-based knowledges and the ever-present risks of depoliticizing or co-opting c/s/x activist knowledges within academic spaces (McWade, 2020).

By “Mad archival work,” I am referring to the formal kinds of work undertaken to assemble and affirm our collective history as one worth preserving. As Mel

Starkman described in a 2009 interview, a psychiatric survivor archive “is the living heritage of the people who had been in the movement.”<sup>3</sup> By Mad archival work, I am also referring to the informal collecting and digging through our material history: the newspaper clippings, photographs, VHS tapes, and newsletters saved in personal collections. This work involves dusting off and fleshing out the stuff of the movement, in order to produce the archives. As with much c/s/x movement history, the documentation chronicling this history is fragmented and requires preservation. What’s more, in the last few years, we have lost a number of Toronto-based early c/s/x movement leaders, including Diana Capponi (1953–2014), Pat Capponi (1947–2019), Mel Starkman (1942–2019), and Bonnie Burstow (1945–2020). This history is also about all of the people who have been part of this movement whom we don’t yet know about. Honouring their contributions to our movement means bringing their work to light and preserving it in ways that ensure Mad community access to these knowledges. 🍁

## NOTES

1. The Ontario Council of Alternative Businesses is now known as Working for Change ([workingforchange.ca](http://workingforchange.ca)).
2. Excerpts of this interview are featured in a short web-based documentary. The full interview can be viewed on YouTube at <https://www.youtube.com/watch?v=YDy6gROJ-w>.
3. This filmed interview with Mel Starkman from 2009 is available on the *Madness Canada* website at <https://madnesscanada.com/resources/video/toronto-activists-project/description/>.

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# I've disclosed, now what? Exploring how racialized women with invisible disabilities navigate stigma and disclosure in the workplace

**M**y research examines how racialized Asian women with invisible disabilities navigate stigma and workplace culture in relation to managers and supervisors after disclosing their disability in public work sectors. When I began my research, I requested race, gender, disability, and employment data from Statistics Canada; I was told, “Unfortunately, there is no standard cross-tabulation between visible minorities, disability, and income/education/employment” (personal communication, November 29, 2018). This shows how the lack of data limits the research on the intersections of ethnicity, disability, gender, and employment in Canada. While research exists on disability and disclosure at work, more research is needed to understand whether workplace culture and trust play a role in how, when, and why a person with invisible disabilities discloses (Bonaccio et al., 2019). Invisible disabilities are disabilities that are not easily identifiable (such as cognitive, learning, and pain disabilities). Invisible disabilities also include mental health. The prevalence of mental health-related disabilities is high, as one in five Canadians report experiencing mental distress each year (Centre for Addiction and Mental Health, n.d.).

## UNSEEN, UNSTUDIED

The findings in the only national survey conducted on Canadian attitudes on disability show that Canadians are more likely to think of disability as visible or physical rather than invisible, and more than half of respondents said that they would hide an invisible disability (Prince, 2009). This is important because, arguably, nine of the ten disability categories (pain, flexibility, mobility, mental health, seeing, hearing, dexterity, learning, mem-

BY CINDY JIANG



**Cindy Jiang is a research associate at the Roberts Centre for Canadian Studies, where she is part of the inaugural team of the Critical Perspectives on Mental Health (CPM). She is also a research associate at the York Centre for Asian Research and a member of the board of directors of the Canadian Centre on Disability Studies (operating as Eviance). She works toward creating community and capacity building, and her research focuses on mental health, disability health, and health policy, particularly among racialized populations. Her past research includes looking at how to reduce the stigma of mental illness among Asian men and Mad history in Vancouver. Her current projects focus on diversifying mental health curriculum through the creation and inclusion of racialized experiences of mental health through the arts and providing accessibility in the arts. Cindy is completing her PhD in Critical Disability Studies at York University. She also has an MPH (Master of Public Health) and is a recipient of a SSHRC doctoral fellowship.**

ory, and developmental disabilities) listed on the Canadian Disability Survey could be invisible. This shows the deep-seated pervasiveness of self and social stigmas that persists and how it affects disclosure. In Canada there is both a large population who self-report having

a disability and a large, racialized population. Stigma and cultural understandings of disability influence how people identify with disability, and research also shows that self and social stigmas associated with invisible disabilities (such as mental health) manifest differently among Asian populations (Livingston et al., 2018; Morrow et al., 2019). These are important factors related to racialization and disclosure that may correlate with the wide discrepancies in the self-reported rates of disability among racialized populations (Statistics Canada, 2018). Yet there are few studies that explore how the intersections of gender, race, disability, and ethnicity are negotiated, particularly in the context of work.

Despite the existence of laws and policies (e.g., *Canadian Charter of Rights and Freedoms*, *Canadian Human Rights Act*, *Employment Equity Act*, the duty to accommodate, and *Accessible Canada Act*) to protect people with disabilities from discrimination, there is no formal or rigorous standard by which these rights are supported and made accessible for all. People with disabilities continue to experience stigma when trying to find employment; they have higher rates of unemployment, underemployment, and precarious employment; and they are paid less than their peers (Bonaccio et al., 2019). These figures are compounded by racial and gendered inequities in which racialized women earn less and are less likely to be promoted. A large study conducted in Toronto and Montreal found that people with “ethnic” names, particularly Asian names, received fewer job interviews than people with “non-ethnic” names

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(Banerjee et al., 2018). Such inequities affect how organizations hire and promote from racialized populations.

## WHAT HAPPENS AFTER DISCLOSURE?

The many formal and informal ways in which disability rights are communicated, perceived, and received through personal narratives and daily conversations influence workplace culture and ultimately impact people's choice to disclose or not. For example, ableist, racist, or discriminatory rhetoric in the workplace can negatively affect a person's sense of whether it would be safe to disclose. While disclosure is not required, disabilities can impact all facets of individuals' lives and cannot be easily dissociated from their workplace identity. Furthermore, disclosure is just one snapshot in time. What happens after a person discloses? What does support look like, and what further conversations will be had between employees, supervisors, and work teams, if any? Workplace cultures often value and provide professional development for efficient project management and successful leadership skills. However, there are very few, if any, training sessions to help with skilling up in terms of inclusivity and accessibility related to invisible disabilities from a disability-centred perspective.

Research that addresses disability and other intersections is rare and usually only makes passing reference to race, ethnicity, and disability (Withers, 2012; Erevelles, 2013). Yet race, ethnicity, disability, and gender are intrinsically intertwined, not mutually exclusive, social markers that have a profound impact on one's identity, sense of self, and social interactions (Withers, 2012). People with disabilities who can "pass" as abled are also afforded different privileges (Bonaccio, 2019; Withers, 2012) and can negotiate and decide when, where, and why they disclose. While a racialized person with an invisible disability can "pass" as non-disabled, they will never pass as someone who is not a racialized person

of colour. When ethnicity, gender, and disability are layered in, there are multiple yet simultaneous identity negotiations. There is the continual negotiation of being from a racialized ethnic group *and* a person with a disability *and* self-identifying as a woman *and* feeling the stigmatizing effects of these oppressions. This is also my daily lived experience.

## NOTHING ABOUT US WITHOUT US

Using the concept of "nothing about us without us" and self-reflexivity, I will provide insight into stigma, disclosure, and navigating disability workplace policy. My research will use an intersectionality framework and will draw from critical disability theory, critical race theory and feminist theory, and dis/ability critical race studies. These theories are helpful in understanding intersecting identities of disability, gender, race, and ethnicity and how these identities interact with social positions, relations, roles, and power. My research will impact workplace policy by directly providing insight into the nuances of how disability and disclosure are enacted from a racialized, invisible disability perspective. These insights will be pivotal in transforming the dynamics of privilege and marginalization among racialized populations with invisible disabilities to foster a more inclusive workplace culture. 🍁

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# Depathologizing self-harm: The politics of survival

## CRITICAL MENTAL HEALTH, MAD STUDIES, AND SELF-HARM

As bodies of scholarly thought and activism, critical mental health scholarship and Mad Studies provide frameworks through which harmful biomedical accounts of mental distress can be resisted. Rather than reduce expressions of distress to symptoms of “mental illness” to be treated and cured, these frameworks locate different experiences of distress within the social, historical, cultural, and political worlds that inform them. These branches of thought critically locate “madness” within broader socio-political circumstances while simultaneously fostering engagement with the felt and embodied experiences of suffering and distress, thereby resisting the abstraction of madness to a social, cultural, or political phenomenon. These frameworks challenge the medicalization of emotional distress and engage those deemed “mad” as politicized epistemic agents—that is, engaging the lived experiences of mad people as knowledge that matters. By taking the lived experience of distress seriously as a starting point for analysis, critical mental health and Mad Studies frameworks look beyond individual experiences of mental illness and work to uncover the vast networks of power and inequity that structure, shape, and distribute distress, loneliness, joy, connectivity, and even health.

With regard to self-harm—the intentional injury to one’s body through acts such as cutting, burning, scratching, hair pulling, self-hitting, or biting—critical mental health and Mad Studies scholarship opens space to ask critical questions about the pathologization of—and the urgency of depathologizing—self-harm as an act of survival. When paired with feminist attention to the gendered and racialized dimensions of distress and embodiment, these frameworks also carve out space to explore questions of

BY SARAH REDIKOPP



**Sarah Redikopp is a PhD candidate in the graduate program of Gender, Feminist and Women’s Studies at York University. She received her MA in Women’s Studies and Feminist Research from Western University in 2018 with support from SSHRC-CGSM. Sarah’s current doctoral work, which is generously supported by a SSHRC doctoral fellowship, examines lived experiences of self-harm in contexts of structural violence through an intersectional lens. Her research interests include political economies of mental health and madness, violence and mental health care, Mad Studies, and feminist and queer epistemologies. Sarah has published in areas of Critical Disability Studies and feminist theory.**

control and bodily autonomy, particularly around the fear held by so many about self-harm as a behaviour widely perceived as out-of-control, shocking, attention seeking, or manipulative.

## PSYCHIATRIZING SELF-HARM

Frequently, self-harm is a repeated behaviour undertaken as a way of coping with overwhelming mental or emotional distress. The existing clinical literature on self-harm, which is heavily influenced by biomedical psychiatric emphases on individual behaviour, biology, and “cure,” tends to medicalize self-harm as a symptom of mental illness, or as mental illness itself. The recent coining of non-suicidal self-injury disorder (NSSID) in the *Diagnostic and Statistical Manual of Mental*

*Disorders* (DSM-5) is characteristic of the medicalization of this distress (American Psychiatric Association, 2013). In the DSM-5, to be diagnosed with NSSID, “an individual must engage in acts of intentional self-injury that cause damage to the surface of the body on 5 or more days within the past year,” and this self-injury must be performed in an attempt to

- 1) relieve negative thoughts or feelings, 2) resolve an interpersonal problem, or 3) cause a positive feeling or emotion. NSSID must also be associated with negative thoughts or feelings and/or interpersonal problems immediately prior to engaging in the behavior, preoccupation with the behavior that is difficult to resist, or the frequent urge to engage in the behavior. (Muehlenkamp & Brausch, 2016, p. 548)

Much as borderline personality disorder can be critiqued from a feminist perspective (Redikopp, 2018), NSSID can be critiqued as an attempt to manage “sick” individuals by medicalizing trauma and distress and obscuring the influence of violent structures on the use of self-harm as a coping mechanism.

As a behaviour, self-harm is particularly gendered in that it is disproportionately undertaken by women and girls (almost all extant clinical evidence indicates that self-harm, particularly self-cutting, is more common among these populations). Clinical discourses on self-harm are also aged and racialized in particular ways. Barbara Brickman, in *Delicate Flesh* (2016), explores the “cutter profile” developed by 1960s American psychiatrists as a white, middle-class, generally attractive adolescent girl. Brickman demonstrates how this profile continues to persist as the tragic face of self-harm, particularly self-cutting, and likewise, how medical discourses con-

tinue to produce this figure of the white, adolescent female cutter through imbalanced research and ideological assumptions about embodiment and femininity. Self-cutting particularly is often referred to as “delicate” or “superficial” self-harm, the gendered and racialized connotations of which are directly linked to this normative cutter profile. The myth of the “delicate” white female cutter forecloses effective considerations of what “non-normative” (or marginalized) experiences of self-harm may look like, and remains embedded in clinical research practices.

## DEPATHOLOGIZING SELF-HARM

What these dominant interpretations of self-harm fail to consider is how self-harm is not simply about “harming” the self, but about coping with structural and systemic distributions of violence and inequity. Drawing on critical mental health, Mad Studies, and feminist frameworks, my dissertation undertakes a sustained intersectional analysis of self-harm through a lens of structural violence. Rooted in Black feminism and feminisms of the global south, intersectionality accounts for the interlocking and mutually constitutive nature of systems of power such as white supremacy, patriarchy, and global capitalism. Examining self-harm through an intersectional lens allows me to be explicit the ways in which race, gender, class, and sexuality work together to inform the practice of and response to self-harm. In doing so, I hope to challenge dominant understandings of self-harm as a behaviour primarily undertaken by young white women and to interrogate the relationships between embodied forms of knowledge and structural worlds of violence. Self-harm is a behaviour steeped in shame, fear, and misunderstanding. Almost without question, self-harm is viewed as a maladaptive and undesirable behaviour or as a tragic expression of suffering that must be stopped. This emphasis on cessation, combined with the intensely feminized nature of self-harm, renders it a site ripe for psychiatric medicalization and control.

What these dominant interpretations of self-harm fail to consider is how self-harm is not simply about “harming” the self, but about coping with structural and systemic distributions of violence and inequity.

As a feminist scholar engaging questions of self-harm, medicalization, and power, and as someone with histories of self-harm, my work understands self-harm as a rich site of encounter between emotional distress, structural violence, medicalization, and embodiment. Dominant frameworks of responding to self-harm, greatly informed by biomedical psychiatric ideologies of “treatment” and “cure,” situate self-harm as a symptom of mental illness to be dealt with through psychiatric intervention. These frameworks medicalize risk factors, such as poverty and abuse, rather than politicizing them, and the act of self-harm is rendered the primary danger to be “fixed,” rather than understood as requiring a sustained critique of overarching structures of poverty and capitalism, patriarchal and heterosexist violence, racism, colonialism, and transphobia, all of which inform the use of self-harm as a way to cope with or navigate stressful circumstances. Through critical mental health,

Mad Studies, and feminist frameworks, self-harm can be more meaningfully engaged with as a means of surviving violent worlds. 🍁

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# Decolonizing Western psychedelic consciousness: The therapeutic and social implications of Indigenous plant medicine knowledge

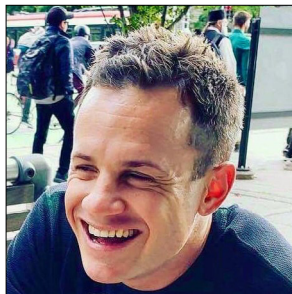
In 2020 Health Canada began granting terminal cancer patients legal exemptions to use psilocybin—the active or “psychedelic” compound found in “magic mushrooms”—as a treatment for distress. The approval, which marks the first time since 1974 that Canadians have been able to take psychedelic drugs legally, highlights the mounting medical consensus regarding the potential of these substances and positions Canada as a global leader in what some critics have described as the “psychedelic renaissance.”

Whether the fast-globalizing movement of psychedelic consciousness will significantly impact the field of Western psychiatry, and mental health care more broadly, remains to be seen. What this moment does provide, however, is an opportunity to reflect on, learn from, and reconcile the history of Indigenous healing and culture, steeped in colonialism as it is, that originally translated knowledge of psychedelic therapy to a wider audience. This history, and the tradition it brings, carries with it significant social and cultural implications for the future of mental health care and collective well-being in the West.

## PSYCHEDELIC HEALING AND ITS IMPACT ON PSYCHIATRY

It is argued that purposive psychedelic use, used in conjunction with psychotherapy, can help people “psychologically as well as physiologically metabolize ... traumas, childhood wounds, addictive patterns, relational issues, health imbalances, and psychological blockages” (Bourzat & Hunter, 2019, p. 44). Scientists, therapists, and underground practitioners propose that part of the

BY JARRETT ROBERT ROSE



**Jarrett Robert Rose is an American international student and a PhD candidate in the Department of Sociology at York University. His research and teaching interests are immersed in social theory and are situated at the nexus of mental health, consciousness, and culture. His dissertation considers the normative social, cultural, and therapeutic implications of the revival of psychedelic healing.**

psychedelic healing process comes from the unique state of introspection it engenders. During the experience, freed from the grips of the ego’s defence mechanisms, unconscious and repressed memories are put under the microscope. This state of consciousness allows the patient to connect on a deeper level with their “autobiographical self”—the inner monologue that links the self with its personal history, interpersonal relations, and the social environment. The resolution of distress comes from *autognosis* (“self-knowledge”), an experience that empowers the patient to unmoor from rigid and ruminative mental and behavioural repertoires. By carefully *integrating* the derived insight from one’s psychedelic journey into daily life, the patient can escape the destructive psychosomatic condition known as “capture,” where repetitive thought and behavioural loops are asso-

ciated with conditions such as addiction, depression, anxiety, and obsession (Kessler, 2016). The result is a subtle yet concentrated “mental reboot,” a development aptly described in the title of Michael Pollan’s acclaimed, *How to Change Your Mind* (2018).

Psychedelic therapy seems likely to threaten the *biomedical* model that currently defines the delivery of care in disciplines such as psychiatry. The biomedical model places the onus of mental distress upon the individual, theorizing suffering as a form of abnormal brain chemistry to be corrected through perpetual, routine, and often imprecise pharmacological interventions. Despite its hegemonic status, for nearly 40 years the model has not lived up to its promise. Many touted claims of efficacy have generally gone unsubstantiated owing to lack of evidence, even after decades of studies and billions of dollars spent on neuroscience research (Deacon, 2013) largely in support of the pharmaceutical industry’s bottom line. In contrast, preliminary data suggest that patients undergoing psychedelic psychotherapy have, often in one or two sessions, achieved positive and enduring results without the need for routine treatments, even for treatment-resistant conditions (Watts et al., 2017; Carhart-Harris et al., 2018). Such promising advancements have led psychiatrists to hesitantly consider using a term that in present-day psychiatry is taboo: “cure” (Sessa, 2014).

Thus, in opposition to the biomedical model, psychedelic healing understands distress in a multi-layered fashion: as the product not just of biology, but of



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a patient's history rooted in social and interpersonal relations. In this sense, psychedelics inspire a more holistic *biopsychosocial* model of distress. Yet, while ongoing research suggests that psychedelic consciousness has already begun refashioning taken-for-granted conventions in Western mental health care, an ignorance prevails over the institution of psychedelic healing knowledge born and translated from Indigenous traditions—a vast and complex history infused with colonial violence.

## DECOLONIZING PSYCHEDELIC CONSCIOUSNESS

Plant medicines have been used cross-culturally in sacramental settings for hundreds and thousands of years, including peyote in the Native American Church, psilocybin by the Indians of Mesoamerica, San Pedro cactus in the Andes of South America, ayahuasca in the Amazonian Indigenous and mestizo healing traditions, and many more. These cultures—each unique in their own ways—operate within *natural* epistemological and ontological frameworks that understand health, the self, the community, and the ecosystem as inherently interconnected. Plant medicines—understood, like nature, as living spirits—are sacred entities from which ancestral and healing wisdoms are derived.

In Indigenous rituals, the function of psychedelic plant medicines is part of a rich institution of collective healing and engagement with past, present, and future. This style of use and appreciation is much more complicated than its reduction by non-Indigenous peoples to a limited, individualized therapeutic device. To reduce these plant medicines to individualistic forms of healing, just as the biomedical model of mental health reduces distress to the brain chemistry of individuals, is to miss the point. The lesson of psychedelic consciousness and the culture it promotes is that of connection to the social and natural environment. As the peoples of the Colombian Amazon have declared:

Western medicine ... looks at the body alone, where we traditional indigenous health practitioners attempt to take in the entire individual and his relationships with others, with nature, and with the world of the spirit. (UMIYAC, 2000, p. 13)

To take these lessons seriously means understanding that adopting psychedelic consciousness in our health care apparatuses will have substantial repercussions, not simply for mental health care, but for Western culture, society, and politics. Embracing these epistemological and ontological frameworks necessitates recognizing that the root of distress lies in our relationships with others. That is, rather than visualize social problems as individual or biological abnormalities, psychedelic consciousness highlights the ways in which health and illness are inherently cultural and political.

While the psychedelic renaissance opens the possibility for much-needed dialogue between cultures, the 500-year history of colonialism casts a looming shadow over the wisdom—of plant medicine and otherwise—translated and transmitted by Indigenous peoples. It is imperative that participants and practitioners in the psychedelic renaissance be mindful of how European science and religion have historically reduced, appropriated, and destroyed Indigenous healing traditions, and have aided in enduring ecological destruction. In the wake of healing our own personal and cultural distress—distress that Western science, philosophy, and technological “progress,” in its *epistemic grandiosity* (Teo, 2019), have failed to resolve in the first place—let us not recreate the same conditions we seek to eliminate. Instead, what is needed is reflection, humility, and, ultimately, reconciliation.

These ancient knowledges demand attention, respect, and dialogue. To move away from mere cultural appropriation toward ethical collaboration requires understanding how the industrialized world continues to exploit, destroy, and

humiliate Indigenous peoples around the globe (Bourzat & Hunter, 2019). Accomplishing this in the long term consists not only of providing material reparations for ongoing cultural and ecological devastation on behalf of colonial and post-colonial enterprises, but of respecting and compensating the cultures in question for the knowledge, artifacts, fashion, and the material and ideational objects derived from the globalization of Indigenous cultures (Tupper, 2009). At the heart of the matter, there is a more important and universal message emanating from these ancient and sacred wisdoms. That message is not just that psychedelic consciousness can cure individual trauma; it is that the individual exists within a symbiotic matrix of social, cultural, and natural relationships. It is time these lessons are taken seriously—our species and the earth depend on it. 🍁

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While my exploration of psychiatric power presented here is not exhaustive, it is meant to give a sense of how the power framework can be used and adapted to better understand how psychiatric power is structured and deployed to shape the ADHD experience.

Finally, this adaptation opens up possibilities for the creation and application of power frameworks in other important areas related to public health, including but not limited to policing, news media, and pharmaceuticals. Power dynamics are central in shaping how health policy is created and carried out. If we aspire

to create more democratic, inclusive, and healthy societies, understanding how power functions should be a priority. 🍁

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