CanadaWatch

RETHINKING, REFRAMING, AND REIMAGINING MADNESS

Guest editors' introduction

The Critical Perspectives on Mental Health/Mad Studies Research Cluster was established at the Robarts Centre for Canadian Studies in 2019. Now in its fourth year, the cluster continues to be a space where scholars can come together across disciplines to share their work in the critical mental health domain. Indeed, work in critical mental health/Mad Studies can be found in a range of disciplines within the academy—sociology, education, health studies, nursing, psychology, history, social work, etc.—but it shares an interest in bringing critical theoretical approaches to the study and examination of mental health in the broadest sense. That is, the subjects of study are vast but typically involve research grounded in social justice paradigms that are seeking to surface, challenge, and change power and power relations as they manifest historically and contemporarily in the "psy" sciences and associated helping professions.

Critical mental health scholars challenge accepted disciplinary discourses by unmasking scientific biases and underscoring the ways in which scientific inquiry is embedded in a larger set of social and political relations that often serve to reinforce existing power relations. Critical mental health scholars are frequently allies with activists/people with lived and living experiences of psychi-

The contents of this issue are listed in the Features box on page 2.

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BY MARINA MORROW AND CINDY JIANG

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atric systems working to change mental health systems and practices and/or to establish entirely new ways of understanding mental well-being.

Since our inaugural in-person event, "Dialogue, Research, Inquiry, Action: Critical Perspectives on Mental Health/Mad Studies Cluster" in February 2020, the cluster has been committed to showcasing the work emerging from our dialogues (see our first edition of *Canada Watch* at https://robarts.info.yorku.ca/files/2021/09/CW-2021-Mental-Health-FINAL.pdf). In May 2022, we held another networking event and, like the previous one, it featured 12 five-minute research presentations by graduate students and faculty under three themes: Constructions of Illness and Care, Mad History, and Youth & Madness & Maddening Experiences. These presentations covered some familiar territory but also introduced new ideas and ways of thinking critically about mental health. It also expanded our circle beyond York to include scholars working in other contexts. The participants were eager to share their work in another edition of *Canada Watch*. In this issue, we feature a group of scholars, both seasoned and emerging, who are all grappling with ways to rethink, reframe, and reimagine madness.

MAD HISTORY

In the first section, we present three articles that bring historical analyses to bear on the historical subjects of psychiatry, institutionalization, and therapy. Each article brings fresh insights related to mad histories, and methodologies for uncovering mad histories, and adds to our knowledge of specific therapeutic practices and institutional settings.

Kira Smith in "Mad Pasts: Reimagining Histories of Madness Through Blended Writing," examines the role of emotions in historical accounts of madness using the methodology of blended writing. Using Canadian archival patient records from 1904, she reimagines the story of Gregory, a mental patient in British Columbia, through an emotional lens. Her article dares us to reimagine what bringing emotions into history might mean for recapturing the lived experiences of historical subjects.

Andrew Jones in "Psychedelic Therapy and the Prehistory of CAMH: Reliving Birth at the Bell Clinic" uncovers some of the complex and controversial medical history surrounding psychedelic therapy with a focus on the Bell Clinic, a private addiction care centre in Ontario. His work reminds us of the ways in which the use of psychedelic therapy is shaped by the prevailing mental health discourses of the day, and cautions us to be mindful of these histories as psychedelic therapy comes back into favour under the discourse of neuroplasticity.

Gregory Klages in "Mad Patients and/or Pioneers? Rethinking Patients Buried at

Rethinking, Reframing, and Reimagining Madness

FEATURES

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Guest editors' introduction

Toronto's Lakeshore Psychiatric Hospital Cemetery" foregrounds the importance of commemorating psychiatric patients who have been buried outside psychiatric hospitals (often in unmarked graves) for what it can tell us about our collective history and reveal about the socially unjust practices that people subject to institutionalization have faced. Klages's study concerns the Lakeshore Psychiatric Hospital in Etobicoke, Ontario dating from 1850.

ANXIETY AND SOCIAL STIGMA

In the second section, we present an article that critically analyzes social stigmas alongside accepted social norms. It presents a pathologized mental health condition to show how underlying stigmas and preconceived ideas of mental health influence societal responses to what is considered "illness."

A.T. Kingsmith in "The Hidden Problem of High-Functioning Anxiety" illustrates the ways in which dominant neoliberal discourses privilege productivity such that it supports a hierarchy with respect to understanding and addressing anxiety. In this context, sufferers with so-called high-functioning anxiety not only go unnoticed but may be lauded for their outwardly ambitious, detail-oriented, and self-sufficient behaviours.

PROFESSIONAL EDUCATION AND MAD STUDIES

In the last section, we present two articles that delve into educational material for practitioners and health professionals in Ontario and, through their analyses, show how the biomedical model is being upheld. Each article shows the complexities and risks associated with educational materials that exclude psychiatric perspectives and experiences, and invites us to think of how to better incorporate mad lived experience in education.

Cindy Jiang, Simon Adam, and Marina Makhail in " 'How Stupid Some Policy Is': A Survivor-Led Critical Discourse Analysis on Mental Health Education" demonstrate how the inclusion of psychiatric survivors' perspectives in mental health education can transform policy, guidelines, and texts to provide survivor-centred support. They show how survivors were able to critically analyze text excerpts used in mental health nursing education and to make recommendations on how to reframe the understanding and power imbalance between survivors and mental health professionals.

Finally, Adam W.J. Davies, Simon Adam, and Lauren Spring in "Mad Studies and Pre-Service Early Childhood Education and Care: Bringing Mad Studies to Future Practitioners and Educators" explore the psychiatrization and surveillance of early childhood educators. They interrogate governance and educational materials and invite us to rethink the various ways in which sanism is embedded in governing bodies, training, and screening tools.

Collectively these articles re-envision the past, present, and future of mad research and reflect the power of critical perspectives that centre lived/living experiences in reframing, rethinking, and reimagining mad discourses. ✦

The Robarts Centre for Canadian Studies will be celebrating its 40th anniversary in 2024!

To this end, two special issues of *Canada Watch* will be published: one on the evolution of the study of Canada over 40 years and the role of the Robarts Centre in supporting research at York University and another one on testimonies of the Centre's impact on people's professional lives.

ROBARTS
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Mad pasts: Reimagining histories of madness through blended writing

BY KIRA SMITH

Kira Smith is a PhD candidate at York University who is studying the experiences of children in Canadian psychiatric facilities from 1880 to 1930.

For over 20 years, historians have made efforts to understand the roles of emotions. In particular, some scholars have examined the ways in which things like pain, power and emotion, sympathy, emotional style, and anger were expressed in the past (Bourke, 2014; Eustace, 2008; Lean, 2007; Stearns, 1994; Reddy, 2001; Rosenwein, 2020). Yet, when we read histories of madness, emotions are curiously under-written.

To address this lack, I turn to blending fiction and non-fiction writing to centre emotions in mad histories in a method known as blended writing. Blended writing allows me to use creativity and emotions in my research to create a mad methodology that pushes our historical storytelling in new directions. By changing how I approach the past, I hope to contribute to a historic consciousness that reflects madness.

REFLECTING MADNESS IN A HISTORIC CONSCIOUSNESS

Blended writing shares similarities with Saidiya Hartman's critical fabulations. Her method addresses gaps and silences by combining archival research with fictional narratives and critical theory (2008, 2021). I also draw from sociology and emotions in my fieldwork, which allows me to think about the emotions I experience in the archive and about their role in research outputs (Kleinman & Copp, 1993). As a result, I am able to translate the affect of the archive to the page (Larsson, 2020; Russell, 2018). Blended writing, then, is a mixing of disciplinary approaches employed to write a history that uses both fiction and non-fiction.[1] This permits me to tell a history of madness that would otherwise be impossible to write—especially because historical records about mad folks have erased their voices in favour of the voices of professionals (Iacovetta & Mitchinson, 1998).

This method, however, is not without its challenges. While emotions serve as an avenue to critique power and the perceived neutrality of archives, issues around empathy as a colonized approach to interpreting emotions, and the ability to access intimacy beyond individual experiences and privilege, remain present (Finigan, n.d.; Hartman, 1997; Smith, 2022). The goal of this approach is to destabilize the traditional methods that continue to uphold marginalization. As a result, blended writing is messy, biased, and imperfect, particularly because we can never really know someone's personal experiences. Therefore, an understanding of positionality, history, oppression and power, and the limits of this method help to navigate and challenge its application.

WRITING GREGORY AND APPLYING BLENDED WRITING

To illustrate the application of blended writing, I wish to share Gregory's[2] story from a file I reviewed while at the Royal BC Museum and Archives in Victoria (Mental Health Services patient case files, 1872–1987; Mental hospital records, 1872–1962).[3] While fictionalized, it is a *true* story. I blur together the facts from the archive with a fictional narrative:

Give our love, the letter reads.

Gregory sits, staring out the window. Despite being surrounded by many, loneliness envelops him.

The administrator writes back to his parents. *You should not visit him. Please do not come. It will only upset him and disrupt his recovery.*

Gregory sits, now looking at another patient. Loneliness continues to consume him.

The Baker boys are leaving today. If only it were Gregory.

The letters continue. The sitting continues. The loneliness grows deeper.

Gregory is not recovering. Gregory is waiting. Gregory is shrinking. Gregory is having more and more seizures. Gregory is disappearing.

In 1904, Gregory was admitted into an asylum by means of a warrant from the justice of the peace.[4] He was 14 years old. Gregory's file stands out because it is unusually thick, but within it there are nuggets of information that cannot be ignored. His file is full of letters from his parents. These letters demonstrated that his parents consistently inquired about him, asking if they could bring their child home. They also sent gifts to Gregory, which he likely never received, and words of love, which I doubt he heard.

It was the letters that inspired me to focus on the loneliness against the backdrop of his parents' writing. The short passage above attempted to showcase the different experiences happening around Gregory's institutionalization. The story also sought to examine what different emotions may have been circulating as a result of these various experiences—his own, his parents', and the administrator's.

In a longer piece of blended writing, I might emphasize how much Gregory cried, and how scared he felt in this strange institution. I would consider the asylum's size compared to him, compared to his previous world. I would think more about how his epilepsy only showed up after he was 10 years old, when a teacher "hit him around the head." It was after this incident that Gregory began to feel pain,

and it was after this incident that the seizures began.

A longer piece would weave Gregory's story into a larger trend of children experiencing trauma and being pathologized for it, or around a pattern of deaths of children within institutions. In doing so, I would bring the strengths of fictional storytelling to add to our traditional histories of institutionalized children (Slotkin, 2005). There would be limits to the closeness of this narrative to Gregory's experience, because that experience is being mediated through several people with particular ideas and goals about what they want to narrate. Ultimately, it is my hope that his story would reveal historical gaps in a meaningful way, while also undoing the erasure of emotions in historical works.

CONCLUSION

Gregory died in 1908, three and half years after his admission. While he was institutionalized, his seizures only got worse. The institution did not offer treatment or care. But Gregory's story is not unique. Many children with epilepsy or intellectual disabilities spent their lives in various institutions.[5] I leave you with what haunts me—a pattern of a failure to care, death, and loss:

> Gregory falls. And falls. And falls. Twenty-five times in one day. He is not getting better. Is he supposed to get better? He only gets worse.
>
> His parents write. *Can he come home? Has he come to his senses?*
>
> Gregory does not know where he is. He falls. And falls. And falls.
>
> The administrator writes back: *There is no change in his condition. He is having severe fits. He is tired.*
>
> And he falls. And falls. And falls. Gregory is scared. Until he is no more. Alone. But gone. No longer in a crowded facility. No longer falling. No longer coming to his senses. Never coming home.
>
> His parents grieve when they receive an unfeeling letter. *Your son is dead.*

NOTES

1. This move toward blended writing emerges from my master's research project, which culminated in a novella entitled *The Red Chair*. While it is a piece of historical fiction, I am also aware of its realness as a historical artifact based on my source materials and my own experiences in the archive (Smith, 2022).

2. Gregory is a pseudonym.

3. The children in the case files of psychiatric facilities are largely people of poor and European backgrounds, like Gregory. This is, in part, a reflection of other colonial and carceral systems that have institutionalized or excluded racialized individuals. It is also a reflection of the fact that while some racialized children were placed in asylums, they were often given little attention there and their records tend to be sparse. This is something I am currently unpacking in my dissertation.

4. A warrant would have prohibited Gregory from being released without consent from official authorities. In Ontario, Geoffrey Reaume wrote that while families could insist on the removal of their relatives despite medical objections, this was not the case with a warrant (Reaume, 2009).

5. A handful of scholars have begun to expose the horrible conditions that children with intellectual disabilities faced in institutions throughout the 20th century (Burghardt, 2018; Dyck, 2013; Malacrida, 2015; Rossiter & Rinaldi, 2018). In particular, a large amount of scholarship is emerging from collaboration with survivors of the Huronia Regional Centre, resulting in greater public discourse around these facilities (Cohen, 2022; Ford & Rossiter, 2017; davis halifax et al., 2018; Rinaldi, 2021; Scott & Rinaldi, 2017; Seth et al., 2015; Viscardis, 2020).

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COVID IN THE HOUSE OF OLD

Canadians have failed our vulnerable elders. COVID-19 deaths in the first wave of the pandemic were staggering, a pattern that persisted. We allowed residents to be locked away from the world. And we still are not adequately supporting workers who deliver crucial daily care.

This is a major issue of our time. Our parents, our children, and our future selves will judge us on the quality of our response.

The Storytelling Chairs

COVID in the House of Old honours and informs. Seven storytelling chairs present powerful narratives of grief, frustration, care and love. We take a deep dive into the topic with our podcast series and extend the project's reach with educational materials. Our traveling exhibit is available for public shows.

https://covidinthehouseofold.ca/

Psychedelic therapy and the prehistory of CAMH: Reliving birth at the Bell Clinic

In May 2022, Toronto's Centre for Addiction and Mental Health (CAMH) co-hosted a global summit on the therapeutic use of psychedelic drugs (such as "magic mushrooms"). The summit, along with Health Canada's increasing openness to making this kind of therapy accessible, reflects the leading role that Canada has recently taken in re-evaluating the medical potential of these unique substances (Global Summit, 2022).

EARLY EXPERIMENTATION

With such enthusiasm surrounding psychedelic therapy, it is more important than ever to dig into and learn from the controversial medical history of these drugs in Canada. Some of this history is well known. For example, in the postwar period, several mental health experts gave drugs like LSD to vulnerable individuals in psychiatric institutions and prisons. At the Allan Memorial Institute in Montreal, the psychiatrist Ewen Cameron incorporated LSD into his CIA-funded "psychic driving" experiments. And in Ontario, the psychologist Mark Eveson gave LSD to inmates at the Kingston Prison for Women. Yet historians have also pointed to cases where psychedelic therapy was practised more ethically. In 1950s Saskatchewan, several researchers pioneered a sophisticated method for conducting LSD therapy and coined the term *psychedelic* ("mind-manifesting") to highlight the positive potential of these substances (Dyck, 2008).

As more and more humanities scholars pay attention to this history, new stories are unearthed. One such story involves the Bell Clinic, a private centre for treating addiction in Toronto that was founded by the influential Canadian physician R. Gordon Bell. In 1967, the Bell Clinic became the Donwood Institute, which eventually merged with the Queen Street Mental Health Centre, the Clark Institute for Psychiatry, and the Addiction Research Foundation to form CAMH. Before this, though, in the early 1960s, Bell implemented a

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purportedly successful LSD therapy program at the Bell Clinic.

Looking at this program provides an opportunity to critically reflect on the theoretical frameworks that researchers impose on psychedelic drugs. Indeed, what is perhaps most interesting about this case is that the psychiatrists involved believed that LSD allowed patients to relive early childhood trauma, or even their own birth. This belief not only shaped patient experiences and self-understandings, but also directed blame toward mothers. Today, scientific claims about why psychedelics work are radically different, and mainly surround discussions of "enhanced neuroplasticity." But, as this historical case reminds us, such claims have a social dimension and can impact how we view ourselves.

FROM PRIVATE RESIDENCE TO PUBLIC INSTITUTE

In 1946, Gordon Bell opened a clinic in his Toronto home that aimed to provide a more intimate approach to mental health treatment. He quickly found that most of the people who showed up were struggling with alcohol use. While some physicians at this time were beginning to recognize excessive alcohol use as a medical issue, many still regarded it as a moral failing. Bell thus saw an opportunity to provide a space for a patient population that had been neglected and stigmatized. As demand grew, he opened Shadow Brook, a larger clinic with over 20 beds for men. In 1954, he expanded again and created the Bell Clinic, which was licensed for in-patient and out-patient services for men and women. Finally, in 1967, Bell built the Donwood Institute on

land he bought near Toronto's Don River. He soon donated Donwood to the government, and it became the first Canadian public hospital to focus exclusively on addiction (Donwood Institute fonds, 2003). By the 1980s, Bell and Donwood were internationally recognized as leaders in addiction treatment.

REACHING BACK WITH LSD

The LSD therapy program at the Bell Clinic began in 1961 and was primarily run by the Canadian missionary psychiatrist Florence Nichols. Self-described as "the first woman missionary psychiatrist," Nichols was introduced to LSD in the late 1950s through a colleague while working in India, where she established a psychiatric unit at the Christian Medical College in the city of Vellore. During her own LSD experience, she relived a distressing episode from early infancy of being left out in the cold. This experience, she claimed, which was corroborated by her mother, gave her more insight into herself than hundreds of hours of psychoanalytic training did (Edmonds, 1962). While Nichols's early use of LSD took place in post-colonial India, she soon travelled to England to work with a colleague who was finding that the drug could even allow individuals to reach back to the trauma of being born.

When Nichols returned home to Canada, she took a position at the Bell Clinic and launched the LSD program. Within two years, she had used LSD to help 100 patients uncover the roots of their problems with alcohol. For these patients, some of whom had been struggling with alcohol for more than 20 years, Nichols claimed that LSD functioned as a "lifeline" by helping them achieve greater self-understanding. The nursing staff at the clinic also played a key role in the program. Mary Epp, the director of nursing who took on a lot of responsibility regarding clinical procedures, described

Psychedelic therapy and CAMH

how nurses were there to support patients and guide them through the LSD experience. To her surprise, "patients have told me, with positive sincerity, that they went through the birth experience under LSD." Since these experiences were often accompanied by difficult emotions, Epp wondered whether "the mother communicates her fear and anguish to the baby" (Epp, 1965). Nichols also felt that LSD experiences were shaped by the "terror or trust" that infants felt toward their mothers.

Bell was impressed with LSD's potential. He had tried it himself and experienced "that unbelievable psychedelic other world" and "the discovery of one's self." He recalled one man who immediately stopped drinking for at least 12 years after one LSD session (Marshall, 1976b). By the mid-1960s, 200 people had been given LSD at the clinic, and a two-year follow-up found that 43 percent remained sober, and another 40 percent had improved ("Doctor Who Gave Truscott LSD," 1967).

By the mid-1960s, however, policymakers and parents became increasingly concerned about unsupervised, recreational use of the drug among young people. As LSD was rebranded as a drug of abuse, research into its medical value diminished. Given his plans to expand the Bell Clinic into the Donwood Institute, Bell decided to drop the LSD program to avoid jeopardizing his reputation.

A REVIVAL OF INTEREST AT DONWOOD

By the 1970s, though, Bell was once again ready to voice his interest in psychedelics. At the time, therapists at Donwood were employing a variety of alternative techniques to promote relaxation, such as tai chi, yoga, massage, visualization, and self-hypnosis. However, Bell still felt that LSD was useful for opening communication in difficult cases. As panic over the drug abated somewhat, he and several colleagues at Donwood thought about persuading the government to allow them to keep using it.

In 1976, as part of this renewed interest, the Donwood Institute hosted a four-week seminar series on LSD therapy led by the Czech psychiatrist Stanislav Grof (Marshall, 1976a). As a leading expert on psychedelics, Grof had supervised thousands of LSD sessions in Europe and North America. He also found that LSD helped people reach back to their birth trauma, or even experience the *transpersonal* (beyond the self) dimensions of the unconscious. When increasing regulations made LSD difficult to access, Grof developed a technique that used fast and deep breathing to induce similar altered states of consciousness. During the 1970s, he and his wife travelled around North America conducting workshops featuring this technique. Although Bell's hopes of once again using LSD did not come to fruition, some therapists at Donwood did end up incorporating Grof's breathing technique into their practice (Strauss, 1980).

CONCLUSION

The story of LSD therapy at the Bell Clinic highlights the social situatedness of claims about how psychedelic drugs work. Many therapists in the 1960s imposed psychoanalytic frameworks about "mother blaming" onto the LSD experience. While today's researchers largely understand psychedelics more through the concept of "neuroplasticity," history reminds us that we should think carefully about the practical implications of these understandings. Indeed, "plasticity" has become something of a buzzword in psychedelic science, and more work needs to be done to assess its rhetorical use. 🍁

> Today, scientific claims about why psychedelics work are radically different, and mainly surround discussions of "enhanced neuroplasticity." But, as this historical case reminds us, such claims have a social dimension and can impact how we view ourselves.

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Mad patients and/or pioneers? Rethinking patients buried at Toronto's Lakeshore Psychiatric Hospital Cemetery

From the 1890s through to the 1970s, a psychiatric hospital—known variously as Mimico Asylum, New Toronto Asylum, and Lakeshore Psychiatric—operated in Etobicoke, Ontario. From its inception, the hospital operated a cemetery, where the remains of more than 1,500 people were buried over the course of almost 80 years. Most of those buried were deceased patients whose remains were unclaimed by family or friends, or whose next of kin were not known. After the hospital's closure, the cemetery was allowed to fall into disrepair, and has only recently begun to receive the attention it deserves. As a site created to help commemorate the institutionalized dead, but where approximately 85 percent of the burials are currently unmarked, the cemetery affords an opportunity to reconsider how those housed within psychiatric care facilities—and, in this case, buried near them—can be more justly remembered within our collective history-making.

HISTORY

The Lakeshore Hospital is part of a network of provincial psychiatric facilities dating back almost 200 years. In 1850, a provincial asylum was opened in Toronto. The ballooning asylum population, however, soon required the construction of supplemental centres.

One of these centres, the Mimico Branch Asylum, was opened in 1890. Initially, the hospital was intended to hold the Toronto Asylum's long-term patients who seemed unlikely to recover. Later, it would become another point of entry into the psychiatric care system.

The preliminary focus on the hospital as a palliative care–type facility created a unique challenge: the facility would hold many patients who would die after having been in care for an extended period, who often were destitute, and who

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were likely physically and/or emotionally disconnected from their families. In these conditions, it was not unusual for the bodies of deceased patients to remain unclaimed. The responsibility for disposing of unclaimed bodies fell to the hospital.

For about 80 years, from the 1890s to the 1970s, the unclaimed remains of more than 1,500 people were buried on provincial government land a few kilometres north of the hospital. The last burial at the site occurred in 1974.

FORGETTING

Within 20 years after the last burial, the site was pretty much forgotten by the government. In 1992, when Ontario Genealogical Society volunteers visited the cemetery, they discovered that the majority of about 150 grave markers (which lay flat on the ground) were sod-covered.

During the 1990s and 2000s, the site became a focus of controversy. A plan to build a crematorium on the site was approved, but members of the local community fought the proposal, fearing air pollution and increased traffic. Although the plan was approved by the Ontario Municipal Board, the provincial Cabinet later overturned the sale because the process did not involve open tendering for competing bids.

Reawakened to its obligations regarding the cemetery, the government commissioned a cultural heritage assessment of the site in 2009. The resulting report

stated, "the Lakeshore Psychiatric Hospital Cemetery is a significant Cultural Heritage Landscape, representing the history of psychiatric care and historic attitudes towards mental illness in Ontario" (URS Canada, 2009, p. 4).

In 2012, recognizing the recommendation, the government erected signage on the site providing information regarding the cemetery's history.

RE-MEMORIALIZING

What, exactly, does the cemetery tell us about our history? This site is the resting place for the remains of more than 1,500 people. From the 1890s to the 1970s, these patients were part of a large public institution; as part of their care regime, they were expected to work Etobicoke's farmland, to build some of its most significant public facilities, and to perform necessary tasks such as growing food and cleaning laundry. The institution they populated also formed a focal point of employment for Etobicoke residents. Owing to the patients' illness, however, we—as a community, and as a larger society—have struggled with how to incorporate them into our history-making.

The buildings, grounds, and cemetery of the Lakeshore Psychiatric Hospital clearly constitute significant value: the grounds occupy a large part of Etobicoke's lakeshore. The buildings have historical importance and provide a prominent focal point in a critical area of the city. The institutional cemetery, though—*difficult to repurpose, in an area of the city that receives little public attention*—has been pushed to the margins of concern. This is characteristic of the concerns that led to the cemetery's creation: located in a swampy area not useful for agriculture, it offered an ideal, cost-effective location to bury "poor," "forgotten" asylum patients.

Mad patients and/or pioneers?

Selective memorialization regarding the Lakeshore Psychiatric Hospital Cemetery reflects a disorienting separation from the past. Public understanding of the hospital and cemetery is bedevilled by the conundrum that we must take into account the exceptional and traditionally stigmatized experiences of the people who used (and still populate) these sites. To manage this challenge, until recently, approaches to the hospital itself have focused on material factors, such as nature or architectural heritage, or the fantastical, such as hauntings (Kearns, Joseph, & Moon, 2009).

The cemetery frustrates these strategies for remembering the past. It complicates public memory by reminding us that mental illness is a part of our communal experience, and that an important part of Etobicoke's historical development hinges on the labour of, and the labour of caring for, the mentally ill. The cemetery's very existence serves as a kind of critique of our society, now, and in the past. And this role continues today, even with the space re-membered as a heritage location. The cemetery serves as a reminder that in the process of trying to selectively forget things about the institution and its patients, we may have fundamentally disrespected the remains (and thus the memory) of those who

> The cemetery serves as a reminder that in the process of trying to selectively forget things about the institution and its patients, we may have fundamentally disrespected the remains (and thus the memory) of those who died in the hospital and were buried in its cemetery.

died in the hospital and were buried in its cemetery.

The Lakeshore Psychiatric Hospital Cemetery poses an intriguing challenge: it is difficult to erase or fundamentally repurpose the site. How, then, might its "stickiness" offer potential to destabilize existing public history? It can serve, I suggest, as a trigger for reconsidering the value of a mental health care facility, and more importantly, the significance—to Etobicoke, to Ontarians, and to psychiatric survivors around the world—of the thousands of people who passed through it, and who, even though they suffered from mental illness, helped build the city. ❦

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The hidden problem of high-functioning anxiety

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High-functioning anxiety (HFA) has emerged as a nebulous, catch-all term to describe anyone who lives with anxiety but manages to function reasonably well on a day-to-day basis. Those characterized (or self-identified) as "high-functioning anxious" tend to be proactive, outgoing, successful, high achieving, put together, and reasonably calm—until they are not. They are the typical "type A personalities" who excel at work and life. HFA is not even a diagnosis recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR). Nor is it limited to the discrete behaviours commonly associated with generalized anxiety disorder, such as interpersonal avoidance, social paralysis, and persistent fatigue.

Spurred by a dominant neoliberal discourse that privileges productivity above all else, discussions of HFA have become amplified in recent years because they emphasize a positive side to anxiety. Since nobody wants the social stigma that comes from acknowledging that they have a problem, HFA allows sufferers and practitioners alike to stress the bustling and instrumental aspects of anxiousness—anxiety can help push a person to perfect tasks at work, get all the chores done at home, to be a more attentive partner, colleague, friend, etc.

However, what someone thinks and feels can be very different from the outgoing, ambitious, proactive, detail-oriented, or self-sufficient exterior they present to the world. And when anxiety accumulates, it can become immobilizing, leaving a person unable to cope with the demanding routines and expectations it once enabled. While, in recent years, there has been a 25 percent surge in reports of anxiety worldwide, making it the most prevalent mental health challenge, in this productivity-driven society, it is virtually impossible to know just how many people struggle with HFA (World Health Organization, 2022). What is clear, though, is that there is an increasingly prevalent correlation between the relentless pressure to be "high-functioning" and the paralyzing guilt of feeling useless and unproductive.

ANXIETY AND PRODUCTIVITY

Despite being celebrated as productive and even beneficial, HFA fuels myriad nervous habits in the body—racing thoughts, lost time, procrastination, cracking knuckles, lip and nail biting—that cannot be so easily separated out from the dominant narratives about productivity and efficiency within the current social and economic order.

As Joanna Moncrieff (2021) points out, capitalism has created a culture of relentless productivity by requiring people to produce enough surplus value to be employable. Whereas in pre-capitalist societies there were many opportunities for people to contribute to their communities, in the capitalist system labour has economic value only if it generates sufficient profit. This process of exclusion from the productive workforce deprives people of a connection with and investment in their communities, thus contributing to individuals' marginalization and demoralization, which are then labelled (wrongly) as mental illness.

If we look at HFA through the lens of political economy—that is, how people's preferences, opinions, and identities are shaped by their material conditions—unemployment and low productivity transform from a personal failing into a socio-political problem that extends beyond the horizon of any one individual and into the everyday norms, values, and contexts that we inhabit, all of which are underpinned by the ways in which we perceive work and working life. After all, it is the unrelenting pressure for increased outputs that transforms one's toxic busyness and self-destructive overwork into "key strengths" that can shine on a resumé.

This marks the problem of anxiety, or any other form of mental distress connected to social structures and processes, as one's own fault and thus one's responsibility to fix. Such thinking inundates any practice or treatment that frames anxiety as something that is wrong with you—be it your own behavioural deficiencies or faulty coping mechanisms—by pushing people to internalize their health and well-being as synonymous with productivity and purchasing power.

YOU ARE NOT THE PROBLEM

Widespread experiences of mental distress are far more than isolated instances of illness to be "cured" by psychotropic drugs or personalized treatments. They point to the ways in which structural deficiencies and imbalances are coded into our lived experiences, compelling us to make excuses for the system but never for ourselves. If a person cannot cope with this rigid, internalized understanding of mental health, they are likely to conclude that they are "abnormal," unwell, or otherwise deviant—in short, that they are "the problem."

According to David Smail, this has created a situation whereby any symptoms arising *within* individuals are divorced from the cultural, political, and economic interactions between people and

High-functioning anxiety

from the nature of the social world we have created (Smail, 1984). Yet anxious people everywhere are connected by a pervasive condition that has spread into our homes and workplaces, our dreams and desires—always tracking along the contours of exclusion and marginalization. How else can we comprehend why racialized or queer people are, on average, more anxious than white or straight ones, or why working-class children are more stressed than middle- and upper-class ones?

When we internalize this dominant capitalist narrative of productivity above all else, which portrays people who rest and take breaks as unworthy of amity and contentment, it becomes an ideological apparatus through which we make sense of the world. As a result, many of the supports on offer are eclipsed by market logics that have little interest in eradicating or even suppressing mental ill-health. All too often, what counts as "help" seeks to expand our capacities to continue producing while remaining unwell, exploiting every possible moment of time and spare resource for the purposes of "self-actualization."

Most treatments on offer today—from enduring psychiatric and pharmaceutical interventions to mindfulness, CBT, and other psychotherapeutics—put forward

> **Widespread experiences of mental distress are far more than isolated instances of illness to be "cured" by psychotropic drugs or personalized treatments. They point to the ways in which structural deficiencies and imbalances are coded into our lived experiences, compelling us to make excuses for the system but never for ourselves.**

increasingly personalized and customized means to such ends. Instead of treating it as incumbent on individuals to resolve their own mental anguish—instead, that is, of accepting the vast personalization of stress that has taken place over the last 30 years—we should be asking, Why has it become "normal" that so many people today are anxious? 🍁

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"How stupid some policy is":
A survivor-led critical discourse analysis on mental health education

BY CINDY JIANG, SIMON ADAM, AND MARINA MIKHAIL

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Policy-makers and researchers often lack the lived experience to create meaningful educational material, policies, or guidelines that impact psychiatric survivors. Policy analysts, or anyone reviewing policy to create and/or update policy, are often those who have obtained a certain level of education, and thus power, status, and privilege, yet they are rarely the ones who will be impacted by such policies.

A closer examination of mental health nursing education and policy guidelines in Ontario reveals how the material reinforces social stigmas in its training of health professionals. The documents suggest that language structured within mental health education is based on the biomedical model, where words are constructed in a certain way to deploy a biomedical discourse that pathologizes lived experiences of mental health. Language has far-reaching complications because underlying ideas can lead to the reinforcement of social stigmas, ostracization, exclusion, and criminalization of survivors. The language used can also influence the creation of pathologies where ones did not necessarily exist before (Adam, 2017a, 2017b; Adam & Juergensen, 2019; Adam et al., 2019). Without the integration of survivor perspectives, mental health care may remain largely biomedically oriented while marginalizing other forms of knowledge.

SURVIVOR-LED CRITICAL DISCOURSE ANALYSIS

While the legitimacy of the mad/survivor identity has recently gained social and political traction (Menzies et al., 2013), mad and survivor perspectives remain largely absent from health education (Adam, 2017a, 2017b), where mental health discourse appears to be largely deployed from the perspective of the "psy" disciplines. This is where the *Demedicalizing Madness* project sought to integrate survivor perspectives into mental health nursing education and policy guidelines through a survivor-led critical discourse analysis (CDA)—an in-depth examination of the linguistic structure of select texts—to make meaning of how the texts and the underlying ideas are understood through survivor perspectives. In a way, this is a sort of reversal of the "institutional gaze" (Foucault, 1995). The goal was to demonstrate that when language is interrogated by people with lived experience, there can be new possibilities for educational material, and policies can be diversified and modified to be more inclusive of those most impacted by them.

With the guidance of two researchers with lived experience, the participants conducted brief CDA exercises (Fairclough, 2001, 2003) of select nursing-specific regulatory and professional organization guidelines, including some provincial legislation that impacts the provision of mental health services. The participants met, either virtually or in person, in groups of two to five people. The participants engaged with various institutional texts, including definitions, policy guidelines, and situational examples, that were located through a literature review and environmental scan (Adam et al., 2022).

SURVIVOR-BASED RECOMMENDATIONS

The findings show that survivors can make important contributions and conduct CDA as co-researchers and co-analysts. The participants identified how biomedical language is alienating and questioned the diagnostic and stigmatizing language. Some of the recommendations for the redrafting of policies and nursing practice guidelines included:

- *Explicitly include the survivor as an active participant in their care.* For example, a scenario might have been phrased as "the nurse, the social worker, and the psychiatrist would together come up with the care plan for the patient," but it could be rephrased as "the survivor, the nurse, the social worker, and the psychiatrist would together create the care plan for the survivor." The former removed the survivor's autonomy with the underlying idea that survivors cannot be in "the driver's seat" for their own care, while the latter makes explicit that the survivor has a presence and a voice.

- *Substitute words.* For example, in "Malcolm learns strategies to communicate and care for Daisy when she is experiencing hallucinations and delusions, such as reorienting her to the surrounding environment" (College of Nurses of Ontario, 2020), the participants noted that the use of the term "reorienting" reinforces the idea that someone may be forcefully returning the person to "reality,"

whereas the use of the term "validating" or "grounding" has the potential to de-escalate the experience, and to do so without pathologizing people's experiences.

- *Provide appropriate context.* For example, using the term "Indigenous" in a text without providing any cultural context as to why it is being included can be confusing or offensive. One participant was triggered by reading "Indigenous" without any context because it tokenizes Indigenous peoples and continues the trauma they experience when seeking treatment and care.

These are only a few of the many recommendations that the survivors suggested to alter the text. Psychiatric survivors are the experts on the effects of policy, as shown in their analyses. Their analyses of how to augment the texts would radically alter the understanding of mental health and more closely balance the discursive landscape of mental health nursing education.

SURVIVORS' EXPERIENCES OF DOING A CDA

Following the focus groups, the participants were asked about their experience of doing a guided CDA. Many of the participants enjoyed and learned from the process and agreed that a survivor-led CDA is "an important process and I think that the whole thing around mad advocacy was [nothing about us, without us] and that really speaks to giving the people that it affects a voice." Another participant noted, "society, as a whole, really doesn't want to hear from people with mental health issues, they're really considered less than, and are treated less than." Survivors are rarely given the opportunity to analyze texts, and one participant reflected that "it was nice to kind of go into how stupid some policy is." Conducting a CDA is often done by highly educated researchers, yet their education and privilege did not provide the expertise comparable to the sophisticated and meaningful analyses the survivors completed. One participant said they liked "critiquing and allowing us to do it in full capacity." Their experience of participating in research studies is that they are asked about "what we're dealing with right now," and excludes their expertise on how to alter the policy text. A survivor-led CDA can also be an emotionally difficult process; as one participant said, "it's fun, but it's very hard because I want to contribute as much as possible, but it can also hurt the mind." The facilitators checked in with several participants when some traumatic experiences were shared.

Survivors are more than capable of conducting high-level textual analyses. It is imperative to include their perspectives in research design, beyond conducting interviews or focus groups. One participant noted, "more public consultation should happen around language," and it is important to "keep pushing and keep allowing people with a voice to actually be heard." We hope that, by showing what is possible, we can integrate survivor perspectives into all mental health education, policies, guidelines, and texts, not just for nursing, but for all professions that provide mental health services.

FUTURE DIRECTIONS

Survivor-led critical analyses disrupt power dynamics in mental health research and help transfer power to the people most affected by mental health practice and discourses. The result co-creates knowledge that can be meaningful to effect genuine change. Survivors are the experts with lived experiences, and they can analyze complex policies, putting forward interventions on both discursive and practice levels. We hope that this research influences the direction for future interdisciplinary research in the health professions—particularly those interested in critically informed research methodologies. 🍁

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Mad Studies and pre-service early childhood education and care: Bringing Mad Studies to future practitioners and educators

Despite increasing awareness of critical perspectives on mental health, the field of early childhood education and care (ECEC) still relies on biomedical accounts of "mental illness." These accounts reify madness, framing it as a "disorder," while advancing individualized interventions as purported "treatments." There is a focus on mental health in pre-service post-secondary ECEC training programs, but it pertains primarily to children's experiences and offers advice on how to intervene and "treat symptoms" while ignoring the reality that early childhood educators (ECEs) themselves might identify as mad (Davies et al., 2022). Mad Studies has begun to reimagine children's experiences with madness by interrogating the pharmaceutical and biomedical logics that infiltrate children's everyday lives (e.g., LeFrançois & Diamond, 2014) and lead to the pathologizing of diverse behaviours and sensations (such as oppositional defiant disorder). Still, the field of ECEC has yet to take up these critiques and instead relies on biomedical/psychiatric hegemony that is then reproduced by the field's very own policies and accreditation standards (e.g., Best Start Expert Panel on Early Learning, 2007; Ontario Ministry of Training, Colleges and Universities, 2018).

To become a registered early childhood educator (RECE) in Ontario, individuals must complete a required accredited program. The discipline's accreditation standards describe the expected vocational learning outcomes that graduates of pre-service ECEC programs should exhibit—a key component of which is the required "foundational knowledge" of children's development (Ontario Ministry of Training, Colleges and Universities, 2018). Mad Studies interrogates the normative "ages and stages" approaches of developmental psychology/psychiatry,

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on the grounds that they pathologize children's diverse experiences, feelings, and behaviours and propagate "progress narratives" that position an able-bodied, heterosexual, neurotypical, cisgender white child as the ideal norm.

PSYCHIATRIZING ECEs

Within ECEC, educators are expected to portray upbeat, happy, always caring, and nurturing dispositions that are thought to be beneficial for the cognitive and neurological development of children's brains (Davies, 2022; Davies et al., 2022). Certain psychological theories (attachment theory, for example) suggest that ECEs take on a maternal role and engage in behavioural modelling that is always "positive" and emotionally regulated, and minimize expressions of "negative" emotions such as anger, frustration, or distress. Such expectations of educators are not only emotionally exhausting and inauthentic, but they also play into the idea that negative and/or complex emotions are incommensurable with happiness (Davies et al., 2022).

Moreover, the governing professionalized bodies for ECEs in Ontario—the College of Early Childhood Educators—asks members to annually disclose if they have been diagnosed with a disability or mental health condition that impacts their ability to "practise the profession safely" (see also Ontario College of Early Child-

hood Educators, 2017). Such forms of professionalized surveillance risk pushing out educators who experience significant mental distress, or who identify as mad or who may frame their experiences using psychiatric language/diagnoses (Davies et al., 2022). Sanism, or the systemic discrimination and othering of individuals who either have mental health diagnoses or are thought to be "mentally ill," is embedded within normative images of ECEs propagated throughout the field (Davies et al., 2022). Put otherwise, ECEs are expected to regulate their feelings, responses, and behaviours during their work while simultaneously being on the receiving end of mental health surveillance from governing bodies. Also important to note is the fact that at the pre-service training level, students who are struggling are encouraged to seek help from mental health services at their universities or colleges, even though such services are often entrenched in medical model approaches and risk labelling the help-seeker as incompetent, thus impacting future career prospects. There is also evidence that similar processes in higher education institutions push out disabled and mad students (Shanouda, 2019).

PSYCHIATRIZING AND PATHOLOGIZING CHILDHOOD

Pre-service ECEC textbooks and courses draw from knowledge in developmental psychology and psychiatry that locate "mental illness" within the brain of developing children. This framing results in the cultivation of a one-dimensional notion of a "normal" childhood and reinscribes medically defined normalcy as the hegemonic order. Consequently, textbooks assigned to pre-service students steeped in developmental psychology and special education educate future practitioners on

how to identify "abnormalities" through such notions as "typical" development (Davies, 2022). For example, the following is an excerpt from a foundational disciplinary curriculum that outlines, with a high degree of specificity, tools and interventions that an ECE is to use based on developmental "stages" of the child (Best Start Expert Panel on Early Learning, 2007):

> Early childhood practitioners can use screening tools to identify special needs or delays in development. . . . [I]t is crucial that early intervention occurs in a timely manner in order to be preventative. . . . Identification of concerns or delays depends on . . . recognizing when the continuum of development is delayed or significantly atypical. Screening tools are valuable . . . as a means of sharing observations and discussing any concerns that may indicate the need for referral of additional support. (p. 62)

As well intentioned as this advice may be, such "screening tools" are tinged by historically influenced eugenicist theories. The late 19th-century and early 20th-century mental hygiene movement, which focused on ideas of social conditioning and early intervention, became hugely influential in the progressive education movement of the early 20th century, ECEC included. Hence, it is necessary to remain critical of these theories and their influence. By incorporating counterhege-

Mad Studies has begun to reimagine children's experiences with madness by interrogating the pharmaceutical and biomedical logics that infiltrate children's everyday lives and lead to the pathologizing of diverse behaviours and sensations.

monic approaches to mental health and Mad Studies frameworks into pre-service ECE training programs, future practitioners and educators will be more aware of some of the fraught and contested politics in the discipline and will have the tools to begin to challenge the continued pathologization of madness and "mental illness" within the field. 🍁

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Madness Canada / folie Canada believes that Mad Studies should pay particular attention to the mechanisms of power and social justice issues. We aim to use history to understand the present and illuminate the future.

Our work draws on diverse experiences, skills and perspectives in recognizing the legacy of Mad Pride within Canadian communities. Contributors to the website include community members, academics, educators and policy makers.

https://madnesscanada.com/

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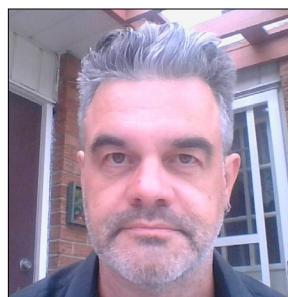
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