

## Welcome

Dear Conference Attendee,

We are delighted to welcome you to Waterloo, Canada for Disorderly Conduct.

The conference brings together scholars from around the world and from such disciplines as sociology, philosophy, health studies, history, women's studies, and medicine to explore and problematize the notion of a "disorder".

Disorderly Conduct marks the first conference of its kind to take place in Canada. The conference's keynote and plenary speakers are leaders in the fields of disability studies, queer theory and sexuality studies and each hold international reputations. Bringing these scholars together with those who are developing research and practice standards in Canada marks an opportunity for the development of ongoing interdisciplinary collaboration between internationally located scholars and graduate students. Following in part from the European model of intensive, issue oriented seminars, this conference brings a distinguished tradition to Canada, and in so doing gathers together participants at various stages of their academic careers and from a broad range of disciplines from the humanities, social sciences and health sciences.

We are particularly pleased that our conference call for papers garnered the attention of *Atlantis Journal of Feminist Studies*, and an invitation from the journal board to publish the best of the conference papers presented. These papers will appear in issue 35.2 of that journal, scheduled to appear in Spring, 2011. If you're giving a talk this weekend, stay tuned for details on how to submit the final paper for peer review for this publication. And, of course, whether you're giving a talk or not, be sure to check out *Atlantis* 35.2.

Thank you all for being a part of Disorderly Conduct, and once again welcome to Waterloo!

Shannon Dea, University of Waterloo  
Morgan Holmes, Wilfrid Laurier University  
Trevor Holmes, University of Waterloo and Wilfrid Laurier University

Waterloo, Canada, July 2009

## Our Featured Speakers

**Stephen Angelides**, the opening keynote speaker is currently a research fellow at Monash University, Australia. Dr. Angelides is the author of *A History of Bisexuality* (U. Chicago, 2001), and a leader in the complementary fields of sexuality studies and queer theory. Dr. Angelides' work challenges taken-for-granted categories of sexuality, and more recently of the emotional and sexual-identity development of adolescents. Dr. Angelides' current work critiques the current vogue for treating adolescence as a disordered developmental stage in which brain function is said to be fundamentally skewed toward destructive and ill-conceived behaviours.

**Robert McRuer** is Associate Professor and Director of Undergraduate Studies in the Department of English at George Washington University, Washington. He has fifteen articles in refereed journals and books, as well as two important monographs and a key edited collection in the field. His *Crip Theory: Cultural Signs of Queerness and Disability* (NYU P, 2006) was a finalist for a 2007 Lambda Literary Award in LGBT Studies and the winner of the 2007 Alan Bray Memorial Book Award (presented by the GL/Q Caucus of the Modern Language Association). His co-edited (with Abby L. Wilkerson) *Desiring Disability: Queer Theory Meets Disability Studies* Special Double Issue of *GLQ: A Journal of Lesbian and Gay Studies* 9:1-2 (Duke UP, 2003) won the 2003 Best Special Issue Award from the Council of Editors of Learned Journals (CELJ). Dr. McRuer has also authored the Afterword for the *Critical Intersex* collection (Ashgate, 2009) that will be the subject of a roundtable at the conference.

**Katrina Roen**. Associate Professor of psychology at the University of Norway, has contributed a number of seminal articles in the field of intersex studies (*GLQ*, 2009; *Social Science and Medicine*, 2006; *Signs*, 2001; *Gender Studies* 2001 -- among others). Dr. Roen's contributions to the critical rethinking of clinical practice and ethics of care have addressed understandings of identity development in children, youth suicide and self-harm, and issues encompassing gender, sexuality, and embodiment. With 19 articles and chapters in print and in production, Dr. Roen's contributions address a range of social justice and health related concerns viewed from a decidedly interdisciplinary perspective.

***DISORDERLY CONDUCT* Programme**

All sessions held in the Bricker Academic Building (BA), Wilfrid Laurier University,  
unless otherwise noted.

**NOTE: Session chairs have been assigned by fiat. Please check to see whether you're a chair. If you're unable to chair that session, please arrange for someone else to do so, or let one of the organizers (Dea, Holmes or Holmes) know that you are unable to chair that session. (Symposium and panel organizers can arrange their own chairing.)**

**Friday, July 24**

9:30-10:30

**Registration**, BA Lobby.

10:30-12:00

**Welcome**, BA 101: Joan Norris, Wilfrid Laurier University.

**Opening Keynote**, BA 101: Steven Angelides, Monash University, "Disorder as a 'Pseudo-Idea'."

12:00-13:30

**Lunch**, Science Atrium.

13:30-15:00

Session 2.1 **Disordering the DSM**, BA 111

Lynda R. Ross, Athabasca University. What happens when we start looking at relationship "problems" as attachment "disorders"?

Daniel Patrone. Union Graduate College Mt. Sinai School of Medicine. Suffering, Controversial Choices, and Persistent, Contentious Disorders

Stephanie Guthrie, York and Ryerson Universities. The Marriage of Psychiatry and Capitalism

**Chair:** Kelly Anthony, University of Waterloo

Session 2.2 **Clinical Subjectivities**, BA 112

Stephanie Speanburg, Emory University. Fine Lines Carved in Flesh: Delineating Subversion from Submission in Gender, Borderline Personality Disorder

Kristin Ireland, Queen's University. Crossing Borders: an exploration of sex reassignment surgery in Ontario's history

Samantha Copeland, Dalhousie University. Psychopharmacology and the Nature of Psychiatric Disorder

**Chair:** Bryn Choppick, University of Waterloo

Session 2.3 **Experiencing and Managing "Self" and "Other"**, BA 113

Amanda Campbell, Wilfrid Laurier University. M/Other: Reproducing Otherness in Birthing Difference

Erin Dej, University of Ottawa. What Once was Sick is now Bad: Charting the discursive shift from pathologized victim to deviant identity for those diagnosed with fetal alcohol spectrum disorder

**Chair:** Hilary Clark, University of Saskatchewan

15:00-15:15

**Break**, BA Lobby.

15:15-16:30

Session 3.1 **Critical Intersex**, BA 101

Roundtable with authors of the forthcoming collection from Ashgate Press: Morgan Holmes, Lena Eckert, Margreit Van Heesch, Alyson Spurgas, Robert McRuer

Session 3.2 **Names Can Never Hurt me: How Health Care Professionals' Training Ignores the Power of our Diagnostic Labelling**, BA 102

Roundtable with University of Waterloo's Kelly Anthony, Sandra Bullock, Christina Mills, Steven Mock, Suzanne Tyas

17:00-18:00

**Reception**, WLU Grad Lounge (between John Aird Centre and Arts).

6:00-

**Free time/dinner on your own.**

**Saturday July 25**

8:30-9:30

**Registration**, BA Lobby.

9:30-10:30

Session 4.0 **Featured Plenary**, BA 101: Robert McRuer, George Washington University, "No Future for Crips: Disorderly Conduct in the New World Order."

10:30-11:00

**Break**, BA Lobby.

11:00-12:30

Session 5.1 **Symposium: Ruling Disorderly Conduct: The uses of Dorothy Smith's relations of ruling for revealing psychiatric violence**, BA 111

Rachel Gorman, University of Toronto. Disorderly Children: Hyperkinetic reaction of childhood, behaviour modification, and the violence of diagnosis

Erick Fabris, OISE-University of Toronto. Disorder and Insight: Cycling of evidence, chemical incarceration and community treatment orders

Naomi Binder Wall, Laurentian University. Revealing Conversion Disorder: Hysteria, rheumatoid arthritis, and iatrogenic illness

Session 5.2 **Resisting and Reframing**, BA 112

Heidi Rimke, University of Winnipeg. Disorderly Subjects: Psychocentrism, Resistance, and the Normative Construction of Disorder

Hilary Clark, University of Saskatchewan. Disorderly the Oedipal Narrative? Interpretation and Resistance in Melanie Klein's *Narrative of a Child Analysis*

Lisa Dias, Wilfrid Laurier University. Understanding *Agonias* via the Habitus

**Chair:** Samantha Copeland, Dalhousie University

Session 5.3 **Embodying and Embracing Disorder**, BA 113

Bryn Choppick. University of Waterloo. Disordered Bodies

Christopher Riddle, Queen's University. Disorders, Disability and Equality

Kristen Hardy, York University. Queering Bellies: (Re)reading Desire, Orientation and the Fat Male Body

**Chair:** Monica Cowart, Merrimack College

12:30-14:00

**Lunch**, BA Lobby

14:00-15:30

Session 6.1 **Symposium: Making Room for Rupture: Disability Studies Organizing Against Biomedical Orders**, BA 111

Katie Aubrecht, OISE-University of Toronto, "Don't Lose your Heads": A Disability Studies Examination of the Crisis in Student Mental Health and Illness

Anne McGuire, OISE-University of Toronto, Representing Autism: A Sociological examination of contemporary Conceptions of Autism in Advocacy

Jijian Voronka, OISE-University of Toronto, Disorderly Diagnosis: Resisting Psy Comprehension through the Media Case File of Britney Spears

Session 6.2 **Contested Sites: Disorderly Resistance**, BA 112

Patricia Elliot, Wilfrid Laurier University. When the Data Fight Back: Debating Alice Dreger's defence of Michael J. Bailey

Robert Davidson, University of Amsterdam, and Lena Eckert, University of Utrecht, Disorders of Sex Development: terminological debates

**Chair:** Samantha Brennan, University of Western Ontario

Session 6.3 **Symposium: Gender Identity and Politics in the DSM**, BA 113

Monica Cowart, Merrimack College. Gendered Deconstructions of Adolescent Rape and PTSD

Gordene MacKenzie, Merrimack College. Whose Disorder: Gender Identity Disorder and Cultural Warfare

Mary Marcel, Bentley College. Pseudo Love: Pedophilia and Epehebophilia as Corrupt Psychological Terms

15:30-16:30

**Waterloo Park Conversations** (weather permitting).

16:30-18:00

**Free time**

18:00-20:30

**Banquet**, UW University Club.

18:00-18:45 Arrival and cash bar.

18:45-20:30 Dinner.

**Sunday July 26**

8:30-9:00

**Registration**, BA Lobby.

9:00-10:30

Session 7.1 **Symposium: Queer Corpo(realities) of Transgender, Intersex, and Disability: Towards a Coalitional Politics for Bodiosexual Justice**, BA 111

Bethany Stevens, Morehouse College School of Medicine and Sunny Nordmarken, Georgia State University.

Session 7.2 **Interrogating Normative Presuppositions and Prescriptions**,  
BA 112

James Overboe, Wilfrid Laurier University. Affirming 'Disorderly Conduct  
by applying Post-structuralist Theory to a life

Samantha Walsh, OISE-University of Toronto. My Personal Trainer and  
My Culture Want me to Walk More

Joseph Mancuso, University of Waterloo. Controlling the Body: the  
history of the gym

**Chair:** Lisa Dias, Wilfrid Laurier University

Session 7.3 **Discourse and Power: Rendering persons as problematic  
groups**, BA 113

Rachel Crawford, Wilfrid Laurier University. Aboriginal Docile Bodies:  
First Nations and TB

Marie Lovrod, University of Saskatchewan and Lynda R. Ross, Athabasca  
University. Post Trauma: The social/political consequences of anxiety  
disorders

Christine Kelly, Carleton University. Noncompliant Patients: The  
Independent Living Movement and Midwifery

**Chair:** Heidi Rimke, University of Saskatchewan

10:30-11:00

**Break**, BA Lobby.

11:00-12:15

Session 8.0 **Closing Plenary**, BA 101: Katrina Roen, University of Oslo.  
"Variant Clinical Discourses: problematising the conceptual foundations  
for clinical interventions with gender variant youth."

12:15-12:30

**Closing Remarks**, BA 101: Morgan Holmes, Wilfrid Laurier University  
and Shannon Dea, University of Waterloo

Sunday afternoon: optional excursion to Stratford, Ontario to view  
performance of *Cyrano de Bergerac*. Email  
disorderlyconduct2009@gmail.com for ticket information.



## Abstracts (Alphabetical by Author)

**Steven Angelides, Monash University. "Disorder as a 'Pseudo-Idea'."**

In the tradition of Western metaphysics the concepts of "order" and "disorder" invariably invoke—indeed, are themselves constituted by and constitutive of—sequential and linear temporal logics. Within these logics order functions as the privileged term, the norm, that which is primordial and prior to the differences that routinely go by the name of disorders. Disorders figure not only as secondary, temporary, or erroneous re-iterations of prior orders (biological, psychological, epistemological, or social). They figure also—as the prefix of 'dis' suggests—as *negations* of these orders. Disorder works, in other words, against the natural or normative order(s) of life. Where order is naturalised, idealised, and perpetually pursued, disorder is lamented, depreciated, or pathologized as something to be corrected, cured, or transcended if not in the present tense then in an imaginary future order. But what is this notion of disorder that functions as order's negation? Of what does it consist? And what is its relationship to order? Is it a simple binary pairing the likes of which poststructuralism and deconstruction have sought to dismantle?

This paper is divided into four sections, three of which correspond loosely to three moves of deconstruction, and the final section which gestures toward the "beyond" of deconstruction. The first section identifies and interrogates the antithesis of order and disorder, and the sequential and temporal logics of which they are entangled. It begins with a discussion of the ways in which the order/disorder binary conditions the formation of other binaries that have been the subject of profound critique and deconstruction in various fields. Notable amongst these are normal/pathological, hetero/homosexual, and able-bodied/disabled, where the first term typically designates the normative order and the second a deviation, or, dis-order to be restored to "proper" order, or at the very least to be explained. The second section seeks to reverse the hierarchy of order/disorder by considering the utility of the "idea" of disorder. It suggests that precisely because oppositional pairs are habitually *ordered* through a series of negations, a focus on the "idea" of disorder provides fertile ground for contesting critical moves of the logic of metaphysical binarism in its establishment of normative orders. The "idea" of disorder, it is argued, is a window not onto an alternative and less normative order, but onto the social, political, epistemological, and particularly *aesthetic and affective* investments, interests, and judgements that make order possible. The "idea" of disorder will be discussed as *enabling* important interdisciplinary conversations between some of the fields for which the

notion of disorder figures so prominently, such as science and biomedicine, GLBTIQ studies, disability studies and crip theory.

The third section of the paper seeks to displace the “idea” of disorder. Drawing on Georges Canguilhem’s philosophy of normality and pathology in biomedicine and Henri Bergson’s philosophy of order, negation and differentiation, the paper proposes that “disorder” is a term without a referent, a “pseudo-idea”. The argument made here is that whilst disorder has a certain practical efficacy, this is where its validity and value ends. As a substitute for disorder, a resignified Bergsonian concept of “order” is offered as a way of releasing the differences suppressed by the “idea” of disorder. This substitution, or displacement, is framed as a supplement to deconstruction, an opening to the universe of irreducible difference of which deconstruction yearns.

The fourth and final section concludes with a peak into this universe. By diffracting “Bergsonism” through quantum physicist Karen Barad’s theory of “agential realism”, the paper links the notion of irreducible difference to ethics. The notion of “disorderly conduct” is refigured not so much as a form of defiance of normative orders than as a reminder of the ethical accountability attending one’s inevitable entanglement with and complicity in maintaining such orders.

**Katie Aubrecht, OISE-University of Toronto. “Don’t Lose your Heads’: A Disability Studies Examination of the Crisis in Student Mental Health and Illness”**

In August 2007 Prime Minister Stephen Harper announced the new Mental Health Commission of Canada, a key recommendation of the 2006 report of the Senate Standing Committee on Social Affairs, Science and Technology entitled “Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada” (CIHR September 17, 2007). The Commission, which was “created to focus national attention on mental health issues and to work to improve the health and social outcomes of people living with mental illness”, has helped bring mental health and issues to the fore of Canadian institutions, not least of which includes Canadian educational institutions. This interest in focusing attention on, and improving the mental health of people living with mental illness was also taken up at the October 2008 Meeting of the Canadian Association of Graduate Schools in Edmonton, Alberta. At the meeting, Lisa Brandes, Assistant Dean for Student Affairs at Yale University, gave a presentation on the current crisis in student mental health. Brandes situates her work in a body of research on the “rising rates of serious mental illness on campuses”; including depression, sleep disorders, substance abuse,

anxiety disorders, eating disorders, impulsive behaviours and even suicide.

The proliferation of discourses on student mental health and illness is helping it to become one of the dominant modes of interpreting and negotiating student survival and success in postsecondary education. What are the socio-political implications of the growing sense on university campuses across Canada that mental disorder in university students is not only “normal”, but a fact of student life? This paper analyzes how textual representations of student life currently in circulation in Canadian universities condition the appearance of a mind/body split in knowledge about a crisis in student mental health and illness. I consider how, in the university context, this split produces a normative demand that students learn to abstract their understandings of themselves from their social contexts and lived experiences of embodiment. Using a Disability Studies perspective, which offers “a critique of professionally generated disability-knowledge” (Titchkosky, 2000: 214), I focus my analysis on three texts currently in circulation at the University of Toronto: “Do You See Me?” (2008), “Coping with Stress at University Exams” (2008) and “The Student Body, Mind and Spirit” (2008). I examine how these three texts produce a collective understanding of a prevalence of mental disorder in the graduate student population, which is in turn represented as completely knowable and treatable given better direction to existing psychiatric services and deference to expert knowledge. In privileging notions of an individualized and detached rationality capable of judging students’ ability to self-govern in times of stress, medical regimes, Canadian bureaucrats, university administrators, professors and the students themselves all help to erect barriers to alternative ways of perceiving the current state of affairs in the university as anything other than a “problem” with graduate student mental health and illness. How can we learn from the lived experience of what has come to be identified as a problem with student mental health and illness? What provides for the persistent refusal to accept that there are other ways of encountering and responding to the appearance of self-doubt in students which do not necessarily end in overtly medicalized and psychiatrized diagnoses and treatments?

**Naomi Binder Wall, Laurentian University. “Revealing Conversion Disorder: Hysteria, Rheumatoid Arthritis, and Iatrogenic Illness”**

This paper emerges from an ontological investigation of the institutions of psychiatry and medicine, with a particular reference to women, in which I use my mother’s life story as a wedge into the ideologically mediated social relations of these particular institutions. The study was guided by interrelated questions. How is a systematic maze of

approaches to women's health—grounded in the assumptions that women are naturally hysterical and pathologically inclined—maintained? Through what institutional operational processes and procedures is this perception of women constructed? By what means? These questions led me to Dorothy Smith and the methodology she posits for the explicative investigation of institutions. Smith poses the problematic: How does this happen to us as this does? (Smith, 1987, 154). An ontological investigation of institutional psychiatry organizes the inquiry around this problematic and acknowledges the immediately experienced, and the activities in which the immediately experienced arises are organized and given shape by social relations that can be fully disclosed only by specialized investigation. It located the immediately experienced as the entry point into that specialized inquiry. In this paper, I focus my analysis on the records of: the psychiatric interpretation of my mother's rheumatoid arthritis and depression as 'conversion disorder' (i.e. as physical manifestations of a psychic problem or mental illness); of the medical mis- or re-interpretation of the devastating physical results of heavy psychotropic drugs; and the death certificate that mis- or re-interpreted her death from these drugs as a suicide.

In the early 50s, psychiatry and medicine were seeking to establish that physical pain might be caused by a neurosis, that symptoms might be psychosomatic and converted involuntarily by the patient, from psychic pain to physical pain. In 1953, my mother's family doctor prescribed cortisone injections for my mother's rheumatoid arthritis, and one year later, he referred her for psychoanalysis to the National Institute for Mental Health, in Bethesda, Maryland, as an outpatient. My mother's medical records document the psychiatrist's conclusion that after a year of psychoanalysis, the rheumatoid arthritis had all but disappeared. Nevertheless, from then on, and until she died, prescriptions of barbiturates, narcotics and hypnotics were maintained. Between 1964 and 1970, she was hospitalized three times for injuries sustained from falls resulting from barbiturate intoxication. During her last confinement in 1970, she received electroshock. She died in December 1970. A toxicology report indicates that an overdose of the non-barbiturate sedative doriden had caused the pulmonary edema that led to her death. Dobson notes that institutional ethnography provides a mode of investigation opposed to the production of people as objects who disappear and are replaced by idealized abstractions (Dobson, 2001). Thus, the investigative process begins from the point of view of the woman/subject, which enabled us to magnify our understanding as women of how things come about for us as they do. Our subject is located in her everyday world instead of the space constituted by the objectification resulting from the inventions of the relations of ruling. This approach uncovers the social relations that organize the subject's

experience (Smith, 1987). Thereby, my mother's lived experience becomes a wedge into an explication of a broader reality.

**Amanda Campbell, Wilfrid Laurier University. "M/Other: Reproducing Otherness in Birthing Difference"**

The maternal body is one which occupies a paradoxical social space; it is romantic, noble, and selfless, while simultaneously consuming, grotesque, and abjected/abjecting. The latter part of this dual discourse surrounding motherhood is very present when discussing the (re)production of disability, disorder, disease, or "deviance" in the bodies of children born from maternal bodies. The maternal, and thus, the female body becomes viewed as accountable, responsible, blameable, and corrupting, as well as corrupted and monstrous, in relation to the socially and medically abject bodies they carried and brought into being. This is especially evident in clinical discourses which seek to erase variance among human bodies. The maternal body comes to be regarded as a gateway to and of socially and medically unviable non-subjects, producing the mother's own subjectivity as medically and socially questionable, as well; surgery thus serves to also correct and conceal the externalization of the internal monstrosity of the maternal body.

**Bryn Choppick. University of Waterloo. "Disordered Bodies"**

In *The History of Sexuality: An Introduction*, Michel Foucault argues that "the disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed." (139) This situates how modern operations of power have replaced the threat of death with the control over life, employing a spectrum of power-knowledge about the body that functions through the control of both the micro and macro level of its uses. Indeed, throughout the course of his major works, Foucault proposed an analytic description of social hegemony that is decentralized, productive instead of repressive, and is exerted through institutional and individual practices of judgment and discipline of the body. This model might be best characterized through the use of his term "bio-power". Foucault posits one of bio-power's central functions as acting as a force of normalization, achieved through the surveillance, distribution, specification and hierarchization of "delinquent", or disordered, bodies. Hence, the body becomes a central location for the investment and production of bio-power.

I would contend then that this conception of the body as a locus of power – one that is always already positioned within a larger institutionalized continuum of normalcy and deviance – suggests that the discourses concerning addicted populations constitute an important area of research for contemporary Foucauldian analysis. Thus, this essay will employ a Foucauldian perspective to examine the cultural implications of the legal and psycho-medical labeling of individuals as being afflicted with an addiction disorder, and consequently positioning them in society as an “addict”, while imbricating them in a discourse of “addiction”. Operating from a position that asserts that the “addict” diagnosis might perform certain functions of bio-power, I will deploy post-structuralist concepts of discourse theory and power relations to examine the possible effects on individual lives and the social constructions manifested by this discursive subject-position. As a result of its centrality for diagnosis in Western culture, the DSM-IV description of substance abuse and dependence will be employed as a textual launching point for this discussion.

Through this investigation of the relation between addiction discourse and bio-power, I will address the following issues: How do institutional discourses about addiction intersect with individual and popular perception? What role does the technology of the “confession” play in the discourse of addiction? Does the diagnosis and study of addiction constitute a form of controlled delinquency? What cultural effects might the editors of the DSM-V be conscious of in constructing a modified discourse of addiction diagnosis? Ultimately, the aim of this discussion will be to situate what functions of bio-power the “addict” label embodies or produces.

**Hilary Clark, University of Saskatchewan. “Disordering the Oedipal Narrative? Interpretation and Resistance in Melanie Klein’s *Narrative of a Child Analysis*”**

To speak of disorder is to imply a norm against which a disorder is registered as a deviation. Most of the guiding questions suggested in the Call for Papers of this conference appear to be posed within this understanding of disorder. There is clearly a critical perspective on the practice of diagnosis, in which a decision is made regarding whether a symptom falls within the norm or deviates from it, becoming a sign of (a) disorder. A diagnosis may be seen as a form of interpretation, one directed toward classification. In general, like a diagnosis, an interpretation is not acceptable if entirely subjective or idiosyncratic; instead, like a diagnosis, an interpretation involves applying a set of agreed-upon criteria to determine the significance of a text, utterance, or behaviour. My present research focus is on interpretation in psychoanalysis, particularly child analysis. In therapy (my emphasis in

this paper) interpretations are made to increase the patient's insight into unconscious factors and thereby alleviate his or her distress; nonetheless, the practice is normative—following a particular developmental narrative, a framework (agreed upon within a particular analytic community) by which utterances and behaviours are made to signify.

Interpretation has been and still is “seen as lying at the heart of psychoanalytic activity” (Frosh 74). Its centrality prompts questions such as the following: Is an interpretation tactful or overly intrusive? Could another interpretation be found? As well, to what extent is it shaped by the analyst's investment in a particular set of criteria or master narrative? These questions are important to ask of interpretations of texts, and even more important when the “texts” are human beings. Here the ethical implications of normative interpretation need to be considered—especially in the case of child analyses. The child patient is a “vulnerable subject” (Couser) assumed to be not only ignorant, like adults, of his or her own unconscious meanings but also (depending on age) at a disadvantage—needing to be spoken for—because lacking the verbal sophistication of the analyst.

Child psychoanalysis developed to apply the methods of adult analysis to children, taking children's play as equivalent to free association or dreams as symbolic text for interpretation. The foundational narrative driving the analysis was Freud's Oedipal narrative of the child's progress through unconscious phantasies, desires, and anxieties regarding the mother and father. Klein located these conflicts earlier in life than Freud did, but she did not depart from the premises of this narrative. In this paper I will look at Klein's application of this normative model in her analysis in 1940 of a ten-year-old boy, an analysis recorded in great detail in *Narrative of a Child Analysis* (1960). As Richard plays with toy warships and draws pictures of British planes bombing U-boats, Mrs K. (Klein's term) interprets his anxiety concerning the war in terms of a terrifying war within him—unconscious sadistic and sexual phantasies she points out to him in frequent and graphic interpretations. She draws upon the Oedipal narrative in analyzing the child's words, play, and drawings, and even such behaviours as admiring the weather or checking the time. In doing so, paradoxically, she shows the boy to be both disordered—requiring the intervention of analysis—and (almost) normal. To return to the path, all he requires is enlightenment regarding the meaning of every single thing he does.

But Richard often resists such enlightenment, and this resistance is a different form of disorder, closer to what is meant by “disorderly conduct.” While children are vulnerable, they can also be wily—quite adept at protecting their meanings from adults. I will conclude the

paper by identifying a few strategies Richard uses to resist Mrs. K's interpretations. Though basically a cooperative child, he resists the Oedipal narrative sometimes directly, by denial ("But I love my father!"), and at other points more indirectly, through seeming obtuseness (not-listening), physical symptoms, and restless distractibility, moving from one toy, one activity, to another. However, as Mrs K. immediately moves in to interpret these resistances, the boy soon draws upon a more subtle and effective strategy: in order to stay a step ahead of Mrs. K., he learns the rules of the interpretive game and identifies the meanings of his symbols for her, in her terms: for instance, by telling her that details in a drawing stand for his babies with his mummy. In thus anticipating the analyst's moves, he shifts the text to be interpreted and closes the distance between patient and analyst, subtly undermining her authority. He runs this resistance, as analysts often do, in order to preserve the privacy of his meanings.

**Samantha Copeland, Dalhousie University. "Psychopharmacology and the Nature of Psychiatric Disorder"**

The growing field of psychopharmacology provides a distinctly rich ground for theorising about the relationship between new technologies and our conceptions of mental health. Psychopharmacology straddles the traditional divide between body and mind in a way that forces us to reconsider former boundaries, and provides an opportunity for analyzing this reconsideration. The most prominent divide straddled by psychopharmacology is the fuzzy boundary between disorder and discrimination: We can choose a model of disorder framed by discussions of pathological origins and magic bullet drugs, or we can choose a model of disorder in which our concepts of mental health are conditioned by cultural values and available technology. Which choice we make has an impact on how we observe and organize the results and implications of psychiatric drugs. This paper will focus on how the models chosen when using pharmacological treatments for psychiatric disorders influence current research and methods of psychiatric diagnosis.

In particular, I examine the potential of Dan J. Stein's approach in *Philosophy of Psychopharmacology* as a method for judging the value of available models. Stein proposes an embodied approach that emphasizes the relationship between psychiatric and biomedical models, rather than emphasizing their differences. Stein envisions psychopharmacology as a resource for research into the viability of various models of the mind-brain. Stein's approach offers a way to span the divide that psychopharmacology straddles. Rather than regarding and organizing the results of psychopharmacological



treatment and research according to traditional models of disorder, we are challenged to conceive of psychiatric variability in new ways. Stein's embodied approach allows us to do this without also forcing us to choose between biomedical and psychiatric models.

I argue in favour of an embodied approach such as Stein's in conceiving depression because it provides an appropriate framework for synthesis between psychiatric and biomedical theories. I use depression as a prime example of the difficulties encountered when discussing psychiatric disorder using traditional models of psychopharmacological effects. We are currently left without sufficient reason to choose between the psychiatric, social and biomedical models available to explain depression. Thus, these models leave researchers without sufficient direction for future studies, and treatment without a sufficient justification. If instead we use technology as a resource for gaining insight into the workings of the mind-brain, we can work toward developing better methods for categorizing neuro-diversity. An embodied approach offers a synthesis of traditional categories within which it is easier to imagine how we might avoid having to make the rather stark decision between mental health and disorder that we are now forced to make. I propose that breaking down the divide between theoretical and clinical approaches to psychiatric diagnosis can begin by taking an embodied approach to psychopharmacology.

**Monica Cowart, Merrimack College. "Gendered Deconstructions of Adolescent Rape and PTSD"**

Rape and incest are acts of violence in which the perpetrator uses his/her "power over" the individual. A common misperception concerning rape is that the violent act is performed to satisfy sexual desire. This misplaced emphasis on sexual satisfaction takes attention away from the larger issues of domination and control, which motivate the crime. Since survivors of rape often experience symptoms ranging from outbursts of anger to feelings of detachment to flashbacks after the sexual assault, a diagnosis of Post Traumatic Stress Disorder (PTSD) is often assigned. The diagnosis and treatment of PTSD after a rape becomes more complex when the survivor is an adolescent.

This paper will focus upon how the diagnosis of PTSD presents its own host of challenges for the treatment of adolescent rape survivors. In general, I will argue that stereotypes concerning gender and sexuality directly impact how the survivor attaches meaning to his or her trauma. Specifically, I will discuss the double binds that surface for female survivors and demonstrate how they differ from the double binds faced by male survivors. Two clinical case studies will be provided to highlight

the gender-based challenges that emerge. In short, I maintain that certain PTSD symptoms are viewed as appropriate or inappropriate based upon gender (e.g., boys should not cry and girls should not act numb).

Regardless of gender, the adolescent survivor often has the added burden of dealing with their family's reaction to the trauma. If the survivor is not supported by his/her family, then there is a chance that a type of re-traumatization can occur, especially if the parents blame the survivor in some way for the rape. Unsupportive and/or blaming responses from parents typically map on to cultural myths concerning sexuality. Specifically, the content of these unsupportive statements can be traced to stereotypes involving masculinity, femininity, and sexuality. Given this, I discuss how viewing these statements through a gender lens can help to deconstruct the types of reactions that parents exhibit. Once these reactions are isolated, clinicians can assess whether a form of further re-traumatization is occurring and use this analysis to inform how to proceed with treatment.

I suggest that one advantage of a diagnosis of PTSD for an adolescent rape survivor is that the diagnosis can be used to normalize the symptoms that surface after the trauma for both the survivor and for his/her family. This psycho-educational piece of discussing and normalizing the various symptoms can help combat the gender-based biases that originally led to feelings of blame. This gender-based approach has resulted in survivors stating that they feel that they have regained their voice with (in many cases) the full support of their family. Thus, the diagnosis of PTSD can be a valuable tool for helping adolescent survivors begin the healing process with the support they need from their families.

**Rachel Crawford, Wilfrid Laurier University. "Aboriginal Docile Bodies: First Nations and TB"**

The history of Aboriginal health in Canada is long and complicated. In 1867, the *British North America Act* placed responsibility for Aboriginals and their reserved lands on the new federal government of Canada. This government policy has had a significant influence on the health of Aboriginal peoples in the last 140 years. Throughout this time the Canadian government has adopted various health policies which have hindered Aboriginal communities rather than helped them. An assumption exists today that these policies are in the past, and that the current Canadian government has developed a collaborative framework for addressing Aboriginal health issues. The aim of my paper is to present an analysis which compares the medical discourses that existed around Aboriginal health during the twentieth century with those that

exist in the twenty-first century. Recognizing that Aboriginal health issues differ within each community, I primarily focus my work on examining tuberculosis within the Aboriginal populations of British Columbia. I provide a brief history of the tuberculosis epidemic during the twentieth century, as well as some of the policies the federal government developed to control the illness in Aboriginal communities. Next, I explore the current discussions within institutions about tuberculosis and Aboriginal health by examining two forms of literature. I analyze two sample pieces from the *Canadian Medical Association Journal*, including an article and a medical review. I then turn my focus to the "Tripartite First Nations Health Plan", a policy document that has recently been developed by the First Nations Leadership Council, the Government of British Columbia, and the Government of Canada. Within each of these time periods, I use Foucault's concept of the 'docile body' to examine how the bodies of Aboriginal peoples are constructed. Key to Foucault's theory is that the discipline is not carried out through physical force. Rather, institutions such as hospitals and schools create practices which work to construct the body in various ways, often by subtle means. Through these practices, not only does the individual body become disciplined, but also entire groups, or social bodies. While Foucault's own work is focused on studying European countries such as France, his theory of the 'docile body' provides a constructive way to view Aboriginal bodies in Canada. Throughout the past two centuries, practices within institutions such as the federal government have focused on shaping Aboriginal peoples and their bodies. Medical discourses have been quite successful in disciplining Aboriginal bodies through the use of language and techniques in order to shape and control the Aboriginal 'social body'. As such, though improvements have been made to Aboriginal health, current medical discourses still contain problematic language which undermines Aboriginal peoples' agency.

**Robert Davidson, University of Amsterdam, and Lena Eckert, University of Utrecht. "Disorders of Sex Development: Terminological Debates"**

This paper will focus on how different 'intersex' movements choose certain strategies to challenge the psychological and physiological violations of people who have experienced being diagnosed or living as intersexualized in a heteronormative society in which sex/gender categorizations are exclusively binary. Following a semiotic approach, a key to analyzing these challenges is an interrogation of the language used to discuss 'intersex'/'DSD' and debates that have occurred over terminology.

This paper addresses the controversy surrounding the term ‘Disorders of Sex Development’, or ‘DSD’, through a comparative analysis of the ways in which three social movement organizations (SMOs), Intersex Society of North America/accord Alliance of the U.S., Organization Intersex International of Canada, and Androgen Insensitivity Syndrome UK, have actively engaged in framing processes to further their arguments in debates over the terminology. The strategic use of terminology is seen here as a fundamental tool to achieve certain political changes. Theoretical insights from Melucci are taken as a point of departure to emphasize the production of cultural codes, in this case terminology, as integral processes pursued by contemporary SMOs and highlight the importance of meaning as a contested resource. Debates among the groups over the ‘DSD’ term are analyzed through examining how each group engages in the three core framing tasks of prognostic, diagnostic, and motivational framing.

This article follows previous work that examined internal debates in order to distinguish differing ideological and strategical positions among various SMOs of the same social movement – meaning that members of the movement share either a common ‘identity’ and/or a common political aim. A discursive perspective drawn from the work of Foucault is used to map out a medical discourse on ‘intersex.’ Differences in the frames produced by each of the groups are examined in relation to this discourse and linked to the ideological and strategical stance of each group. These ideological/strategical positions are theorized through a schema that conceptualizes each SMO’s engagement with the discourse as ‘revolutionary’ or ‘evolutionary’. This conceptual framework is chosen to identify the points of departure and desired achievements of each of the three groups.

Within the conceptual framework of distinguishing between revolutionary and evolutionary approaches of the SMOs, what are the possibilities of working from inside the heteronormative boundaries of sex/gender to counter specific hegemonic and exclusive material effects on bodies, lives and experiences as well as the potential to challenge the very construction of these boundaries? What would be the most effective strategies to counter exploitative, discriminating, oppressive structures and the identities produced by and bound to those structures? Can collective action undertaken through identity politics challenge the exclusion and violation of individuals when the identities serving as the collective base were produced with the aim to ‘discipline and punish’?

This paper interrogates underlying frameworks of alliance, identitarian reference points, medical authority, resistance, and political sustainability.

**Erin Dej, University of Ottawa. "What Once was Sick is Now Bad: Charting the Discursive Shift From Pathologized Victim to Deviant Identity for Those Diagnosed with Fetal Alcohol Spectrum Disorder"**

Fetal alcohol spectrum disorder (FASD) is constituted by different networks and institutions. The 'discovery' of FASD in 1973 arose within a specific socio-cultural context that saw the emergence of the War on Drugs, increased reproductive rights for women, and the beginnings of neo-liberalism. The short but rapid history of the creation, introduction and adoption of the FASD identity in both medical and social discourses is worth questioning so as to consider who is diagnosed with FASD and why. This is especially intriguing given the frequent association between FASD and Aboriginal populations. The swiftness with which FASD became recognized by the medical model illustrates its diagnostic power. The 'mythology of FASD' demonstrates how historical narratives of specific populations and behaviours are connected with a new diagnosis so as to legitimate its medical authority and inevitability.

I suggest that medical knowledges pathologize those diagnosed with FASD. According to the literature, children diagnosed with FASD are victims of irresponsible mothers and poor parenting. With intensive programming provided by provincial governments and advocacy groups in a child's first six years, it is believed that FASD children can overcome the cognitive and behavioural symptoms and reach their 'optimum potential'. There is a great deal of hope within the FASD community and a number of pragmatic solutions are offered to manage the symptoms without questioning the medical discourse itself. The knowledges that dominate the discourse on the 'FASD child' are most often those of adopted White children in homes with educated and resourceful parents. Subsequently we do not hear the stories of those who remain in marginalized communities or who end up in the foster care system.

As children with FASD age the power accorded to medical discourses is transferred to knowledges produced by the criminal justice system. As criminal justice knowledges become the new discursive authority for FASD, those with this label are reconstituted from being victims to being deviant. The educational programming, advocacy and medical literatures no longer contribute knowledges about FASD in adulthood, and it is the criminal justice system who takes up this task, and effectively demedicalize the FASD identity, and reinforce the FASD adult as 'bad' rather than 'sick'.

Using interview and textual data I offer a genealogy of FASD as a psy-identity, and demonstrate that while the symptoms associated with FASD do not differ from childhood to adulthood, their conceptualization

and thus societal and governmental responses to individuals with FASD changes dramatically. This work is theoretically grounded in Hacking's concept of a looping effect, which suggests that the way an individual and their associates make sense of an identity manipulates the identity itself. In order to unpack the reconstruction of the FASD identity in adulthood, I have identified two linked but distinctive loops – that of the promising child and the hopeless adult. These two loops help conceptualize the different institutions, stakeholders and knowledges that take interest in the 'FASD child' and those that constitute the 'FASD adult' identity.

**Lisa Dias, Wilfrid Laurier University. "Understanding *Agonias* via the Habitus"**

Illness and emotions are socially specific and culturally meaningful categories that are expressed and managed by individuals and communities in different ways. Various social and cultural researchers have explored questions of how illness and emotions are understood in particular sociocultural contexts. Among these researchers is Susan James, a cultural psychologist who investigates the expression of an affect referred to as *agonias*, among Portuguese immigrant populations in the United States and Canada. Within Portuguese communities *agonias* (the agonies) has multiple meanings, including religious and moral significances, and circulates in multiple healing systems, including traditional healers and religious leaders. The multiple meanings of *agonias* are contested and erased within clinical practices therefore, it is crucially important to consider the potential effect that this erasure has on individual and community expression.

The expression of *agonias* among Portuguese populations is an embodied experience of illness and emotions that defies Western medical categorization. Existing research on *agonias* tends to focus on ethnographic work with first-generation Portuguese immigrants, making it difficult to measure the extent to which meanings of *agonias* are the same for communities in continental Portugal and the Azores in comparison to Portuguese communities in the United States and Canada. While this research reveals the meanings of *agonias* to be rooted in an individual's experience with illness, death, religion, morality and social conditions the research also addresses a discrepancy between the manner in which the expression of *agonias* is treated by clinical practitioners in North America and managed by communities in continental Portugal and the Azores. Within dominant western medical and psychiatric practices *agonias* is treated as a form of anxiety and/or depression, whereas in Portugal and the Azores it is managed through community compassion.

*Agonia* is not merely a mental state of being rather, it is an experience characterized by holism where the mind, body and the social are integrated. While existing research is able to illustrate social constructions and cultural meanings of *agonias* using a sociosomatic framework, the research lacks a theory for understanding how social structures and meanings are embodied through the expression of *agonias*. Applying Pierre Bourdieu's theory of practice, this paper proposes that the embodiment of *agonias* can be understood via the habitus where the body takes center stage as a meaning (re)producing social agent. The habitus provides a theory for understanding how *agonias* is embodied through the incorporation of social structures and how the expression of *agonias* simultaneously (re)produces the social structure and the habitus. Furthermore, this paper problematizes the clinical practice of encouraging patients to adopt the language of medicine and psychiatry which, because of its reductive and sterile implications, does not accurately encapsulate the lived experience of individuals expressing *agonias*.

**Patricia Elliot, Wilfrid Laurier University. "When the Data Fight Back: Debating Alice Dreger's defence of Michael J. Bailey"**

In his book, *On being normal and other disorders: A manual for clinical psychodiagnostics*, Paul Verhaeghe (2004) argues that "Freud didn't so much shift the frontiers between normality and abnormality as explode them" (108). Yet in the current love-affair with what Roger Lancaster (2003) calls "genetic fetishism," not to mention the popularity of contemporary versions of evolutionary psychology, such boundaries are not only re-established, but defended. One of the recent versions of such boundary reconstruction in relation to gay men and Mtf transsexuals appears in Michael J. Bailey's *The man who would be queen: the science of gender-bending and transsexualism* (2003). In his discussion of Mtf transsexuals, Bailey relies heavily and exclusively on the theory developed by Ray Blanchard (a theory that constructs two types of Mtf transsexuals according to sexual orientation) to argue they are really *maladapted men*. Developed by those who exercise a great deal of power over the lives of transwomen, and whose professional or medical authority enable them to contribute to the DSM descriptions of gender identity disorder, these theories and their popularization hold no small consequence for transsexuals in general, and for those who wish to transition in particular.

As an outsider, my aim here is not to condemn what many trans activists have lobbied hard to include in the DSM for the purposes of obtaining medical treatment. Rather I plan to examine some of the damaging effects of Bailey's representation of this theory about Mtfs. In particular, I want to discuss the surprising defence of Bailey's book by

Alice Dreger that was published last year in *Archives of Sexual Behavior* (2008) on the invitation of Blanchard's and Bailey's colleague and supporter, Ken Zucker. On his invitation, twenty-three responses to Dreger's lengthy article (as well as her rejoinder) were also published in the same issue, which now usefully sets out the multilayered terms of this very fractious debate. My paper will question this model of theorizing Mtf identity that mistakes itself for scientific truth, that disparages alternative models, and that ultimately treats transsexuals with contempt. My main argument is that Dreger's reading of transwomen's responses to Bailey's book as "scandalous" is deeply problematic given the way in which Bailey's theory reinforces stigmatizing boundaries between the normal and the abnormal, thus scandalizing the trans community.

It appears that in the field of gender identity disorder, nothing is ever stable, and those who claim to support the rights of sexual minorities, and to avoid pathologizing forms of gender variance, even those who openly embrace queer methodologies, are sometimes drawn into project of defending against the instability. Thus in grappling over the truth of *others'* disorders, we come up against our *own* disorders; however supported these may be by institutionalized power, hegemonic forms of knowledge, and popular beliefs in the clear division of the well ordered from the disordered. In taking up this particular debate between Bailey and his unruly 'data' who successfully fight back (Gagnon, 2008), especially in the context of Dreger's attempt to intervene in a way she naively hopes will "quell" the tensions that exist, I intend to reveal some of the mechanisms at work in this process.

**Erick Fabris, OISE-University of Toronto. "Disorder and Insight: Cycling of Evidence, Chemical Incarceration and Community Treatment Orders"**

Insight, the ability to recognize our mental illness, requires sound mind. Sound mind occurs when a cogent process of thought is recognized by a psychiatric practitioner, who can then determine whether therapeutic work is necessary. When insight fails, such as when a person is less than reasonable and responsive to practitioners and others, according to psychiatric lore we have evidence of pathology in the body. The evidence that is used against that body, as Dorothy Smith shows, can even reinforce the narratives it authors. Ultimately, the body is to blame. This is the foundational concept that links psychiatric industrial work with modern medical science, both of which have histories of abuse. And as evidence against the personality is now evidence against the body, we have the grounds for institutional interventionism. The industrial work of psychiatry, a prime institution of custodial care, constantly changes according to how bodies may be technologically



managed. In the contemporary context, institutionalization is founded on assessments of mental incapacity as 'illness' and therefore as constituting a danger, according to psychiatric legislation in Ontario (and most other Western jurisdictions). Institutional ethnography provided me with tools, conceptual and methodological, for finding intersections of law and medicine in such practices, and for interrogating non-instructed, non-consensual forced drugging.

In 1999 I started working against Community Treatment Orders (CTOs) with other activists on the local and provincial stage. CTOs provide a kind of legal leverage for imposing drugs in exchange for freedom from facilities. I sought research to contend the use of this new coercion. When I started researching this legal mechanism in 2004, institutional ethnography brought the political dimension into relief. Community Treatment Orders, called CTOs, (or leash laws), usually impose drugs used to restrain inmates by inducing docility or unconsciousness. This is managed through blocking the majority of dopaminergic reception in the brain, what psychiatrists used to call 'therapeutic parkinsonism'. If a person withdraws from drugs, withdrawal can be more devastating than any original distress. A chemical feedback loop of dependency is established in order to drive up production and profit. Thus, a chemical restraint, when imposed indefinitely, and especially when legally coerced through CTOs, should be considered a form of incarceration (if not torture, as survivor and lawyer Tina Minkowitz has said). This does not preclude CTOs being used for completely different purposes, nor preclude a person from doing 'well' while on CTOs. However, the grounds for any such work can be located in cycling of evidence, chemistry, and biological reductionism for the purpose of therapeutic intervention.

**Rachel Gorman, University of Toronto. "Disorderly Children: Hyperkinetic Reaction of Childhood, Behaviour Modification, and the Violence of Diagnosis"**

In this paper I will discuss my own early experiences with ruling relations of educational and medical/psychiatric discourses in order to begin my analysis of the social relations of 'childhood disorderly conduct' from a particular standpoint. My discussion will be guided by the question: 'how are the categories of disorder and normalcy constructed in relation to processes of medical diagnosis?' I will focus on the diagnosis of a behavioural disorder/learning disability in order to revisit the debate over the differentiation between impairment and disability. Smith (1987, 1997) and Bannerji (1995) argue that social analysis must begin from a particular *standpoint* or embodied location, in order to go "beyond the immediate, through the labyrinth of the mediation and organization of social relations and consciousness to the

Minotaur of a post-colonial imperialist capitalism” (Bannerji, 1995, 85). Describing experiences that are marginal to objectified knowledge is not the end of this project, but the beginning. In order to address questions about the relationship between the organization of ‘normalcy’ and how we think about it, I must find a way to connect partial experiences to the largest frame of social organization. By taking one person’s embodied experience as an entry point—my own in this case—I will attempt to reveal the objectified relations that mediate these experiences, and the objectified knowledge that shapes our consciousness about these experiences. I am not choosing my own story as an entry point because it is important in and of itself, but rather because it is not. Rather, I am writing down my experience because it is one of millions of possible entry points into a discussion of the social relations of ‘disorder’ and ‘normalcy.’

The DSM stands as a testament to the historical emergence of psychiatry, eugenics, and social work. Notions of mental and moral hygiene, degeneracy, and deviance lie just under the surface of its classifications and conditions. Read in light of feminist historical sociology that explores the origins of social work and the state surveillance of propriety in industrializing Europe and North America, the connection between the poor house, the asylum, and the DSM, becomes apparent (see Borchorst, 1999; Katz, 1983; Lis & Soly, 1996; Ross, 1993). Furthermore, as Bonnie Burstow (2003) points out, most ‘symptoms’ listed in the DSM are simply descriptions of human behaviours or emotional states, ones that may arise under duress, or as a result of past trauma. The shift required in order to move from *being* in a particular emotional/physical state to *being* ‘disordered’ is a textual (discursive) one—“there is no disorder...unless somebody with authority applies a psychiatric conceptualization as mediated by the DSM” (1300). Being in a particular state of distress has no connection to illness outside of this particular set of social relations. I will my own diagnosis and behaviour modification treatment in the early 1970s in relation to the DSM II (1968) category of ‘Hyperkinetic Reaction of Childhood’; educational expectations and interventions; popular culture (e.g. women’s magazines) representations of hyperactive children as delinquent; and the emergence of Ritalin.

**Stephanie Guthrie, York and Ryerson Universities. “The Marriage of Psychiatry and Capitalism”**

The medicalization of depression, while reducing stigma for sufferers, serves as a complex means to a number of distinct yet interrelated capitalist ends: the reversal of downturns in productivity, and the creation of both medical commodities (i.e. antidepressants) and medical subjects (i.e. those living with depression). This paper applies Foucault’s

theory of biopolitics to the campaign to end depression, which has ironically resulted in an explosion in diagnoses of depression in the early 21<sup>st</sup> century. In order to curb the effects of depression upon productivity in the labour market, psychiatry and antidepressants operate as biopolitical technologies of control and normalization. Meanwhile, technologies used to treat mood disorders (and, indeed, the moods themselves) are commodified, while their consumers become medical subjects. Biomedical knowledge freezes individuals within their mental illness, making it simultaneously a deviation that must be corrected and conversely, an essential part of their being and recognisability to others.

**Kristen Hardy, York University. “Queering Bellies: (Re)reading Desire, Orientation and the Fat Male Body”**

In thinking through the problematic of bodies and their representation, we repeatedly encounter questions of *desire*. Desires of many sorts—for proximity and for distancing, for grasping and for expelling, for becoming and for disavowal—enter into discourses and rhetoric on and around bodily difference, with a persistence that not only precludes the elision of desire from meaningful discussions of the same, but that situates it as a fundamental locus for the study of 'transgressive' embodiment. Such desires are not merely vectors of feeling enacted towards 'things which (already) are', but, in fact, are constitutive of the objects perceived, the subjects which perceive, and, indeed, of the very delineation between the two.

Proceeding from this perspective, a positivistic approach to a coming to knowledge of the world, which presumes an objective reality accessible to human perception and knowledge, gives way to a grounding of critical analysis in a self-reflexive examination of epistemological processes. Paul Ricoeur intimates several dimensions of such a method when he writes:

A separate ontology is beyond our grasp: it is only within the movement of interpretation that we apperceive the being we interpret. . . . Moreover, it is only in a conflict of rival hermeneutics that we perceive something of the being to be interpreted: a unified ontology is as inaccessible to our method as a separate ontology.

With his invocation of *apperception*, Ricoeur pithily references the desired reflexive stance of the phenomenological inquirer, and also reminds us that knowledge is necessarily viewed from a position of accumulated past impressions that themselves are products of a particular historical, cultural, social, and political situatedness. Thus, we never encounter an objectivity, nor a subjectivity, that stands apart

from our lifeworld; there is no vantage point from which we may obtain an objective and comprehensive knowledge of the beingness of that toward or around which we orient ourselves. In Ricoeur's formulation, this epistemological limitation is invoked to serve as the basis and the justification for a phenomenologically oriented hermeneutic pluralism.

In this exercise, I aim to bring this perspective together with insights from Sara Ahmed's phenomenological analysis of 'orientation', to consider a particular pair of visual representations of bodies. In so doing, I encounter a striking example of desires flowing through the hermeneutical circle and interacting with existing cultural meanings and norms of interpretation to shape orientations. The distinct trajectories of interpretation which emerge, in turn repeat and thus tend to reinscribe existent meanings and selectively reaffirm certain desires. Yet, as Ahmed's work suggests, if we are alert to the presence of 'queer' possibilities within moments of disorientation and uncertain meaning, there exists scope for new orientations to emerge.

**Kristin Ireland, Queen's University. "Crossing Borders: An Exploration of Sex Reassignment Surgery in Ontario's History"**

My paper will explore the history of sex reassignment surgery (SRS) in Ontario from the early 1960s until present day. Using archival notes from the 1960 meeting of clinicians at the Toronto Psychiatric Hospital, sources from the University of Toronto funded study on gender identity which began in 1969, and media sources dealing with specific experiences of sex reassignment surgery this paper will examine the impact of transsexuality being labeled a 'disorder' in the Canadian context.

In 1973 the American gay liberation movement forced the American Psychiatric Association to discontinue its categorization of homosexuality as a mental disorder in the *Diagnostic and Statistical Manual* (DSM). This change had a major impact in Canada as well. The shift in ideology which stopped homosexuals from being assumed mentally-ill to being satisfied with their sexual orientation, had a huge impact on the self-perception of homosexual people.

Currently, international transsexual and transgendered activists are waging a similar battle. In 1997, the American group GenderPAC, Gender Public Advocacy Coalition, drafted a resolution to reform the medical diagnosis of Gender Identity Disorder (GID).

There are numerous reasons why Canadian transsexual people and their allies could support this kind of activism. However, one major difference between these struggles is that homosexual activists did not want to interact with the medical community in the hopes of altering their

physical bodies. In the American context of privately funded healthcare, the government will never be paying for sex reassignment surgery. However, Canadian health care is different in some fundamental ways. Thus, my paper will explore the Canadian implications of this debate.

The history of the medical management of SRS in Canada has been far from perfect. Individuals seeking surgery have had to undergo a variety of tests which have often been invasive and troubling. For instance, in the 1960s and 70s it was assumed that *true transsexuals* were heterosexual and that those interested in same-gender relations were transvestites. In her 1972 memoir, Dianna, the first transsexual woman to undergo SRS in Canada tells of a test she undertook to ascertain her sexual object preference. She writes: "The most distasteful test was when I had an apparatus attached to my penis. It consisted of a condom within a test tube that fitted snugly over my penis, this in turn was hooked up to a pressure gauge and the results were recorded in an adjoining room. As part of the test, I was shown a series of anatomical pictures of naked and clothed men, women, and children." With stories such as this one it is easy to understand why much of the American based activism is focused on bringing an end to transsexuality being labeled a 'disorder.'

However, my paper will also explore why, in the Canadian context, maintaining a 'disorder' status for transsexual people can actually be beneficial. The pathologizing of transsexuality has, at certain moments in Ontario's history, allowed the cost of sex reassignment surgery performed at the Gender Identity Clinic in Toronto to be covered by the Ontario Health Insurance Plan. Thus, exploring the history of SRS in the Canadian context is necessary to understanding in which direction(s) contemporary activists can focus their attention.

**Christine Kelly, Carleton University. "Noncompliant Patients: The Independent Living Movement and Midwifery"**

'Disorderly conduct' implies a bounded 'orderly conduct' which patients are expected to comply with. The concept of orderly conduct can be likened to Dejong's (1983) description of the 'sick role' which requires passivity, cooperation, and subordination to medical professionals. In contrast, disorderly conduct is perhaps best embodied through the concept of noncompliance, which was a popular research topic in nursing and medical literature up until the late 1980s. Noncompliance literature addresses how to deal with unruly patients, that is patients who assert themselves as independent decision makers. Undoubtedly, the traditional sick role is waning and what constitutes as orderly and disorderly conduct is blurring. In nursing literature, recommendations on how to deal with noncompliant patients came under harsh criticism

in the late 80s until the mid 1990s as nursing embraced the shift to a more holistic, or biopsychosocial, model of care. In fact, Colodny's 2001 study actually considers the noncompliance *of nurses*. The shift to a more holistic understanding of the patient may be explained by both advances in medical and social sciences that reveal the significance of the social determinants of health as well as the neoliberal shift in health care administration and policy which sees patients as active decision-making consumers instead of passive recipients of care.

This paper will consider two collective examples of noncompliance that demonstrate the continual decline of the sick role. These groups were once considered patients but have branched off to create new roles for themselves, starting with the assertion that they are not sick. The first example is the Independent Living (IL) Movement, an active branch of the disability movement, which argues that disabled people have a right to make decisions about their lives. The IL Movement advocates for control over services, and promotes "direct" funding, a model of support provision where disabled people receive funds from the government to hire and train the care provider of their choice. The new arrangement inverts the traditional caregiver-patient power imbalance as, at least in theory, the disabled person is in charge of the care provider.

The second example is a brief exploration of the regulation of midwifery in Ontario. Like the IL Movement, midwifery is based on the premise that pregnant women are not sick and that they should be the primary decision-makers during pregnancies and birth. However, the regulation of midwifery has significantly changed the practice, leading to considerable debate among feminists and practitioners alike.

The IL Movement and midwifery are on unique but related trajectories. Both groups can be seen as manifestations of neoliberal health policy and examples of the changing role of the patient. Further, while the groups may have started as noncompliant patients, over time the radical assertions were diminished by their increasing relationships with the state. In some ways, these movements have not completely eliminated the possibility of disorderly conduct as they now must comply with new roles determined by the state, but they have certainly changed what counts as dis/orderly, where this behavior takes place, and who monitors it.

**Marie Lovrod, University of Saskatchewan and Lynda R. Ross, Athabasca University. "Post Trauma: The social/political consequences of anxiety disorders"**

Post Traumatic Stress Disorder (PTSD) made its first appearance in the DSM nosology in 1952. It has been revised several times and for one edition was strategically taken out of and then later put back into the subsequent volume. (Friedman, Resick, & Keane, 2007). Activist groups, including feminist special interest groups, lobbied for and applauded its earlier inclusion, recognizing the role the diagnosis played in validating women's experiences (Burstow, 2005). On the one hand the diagnosis serves to acknowledge suffering; on the other it pathologizes experiences associated with recovery and serves to disguise or normalize the roots of that suffering. The term "trauma," as currently used to describe the physical and psychological effects of both acute and insidious experiences of interpersonal and societal violence (Root, 1992), is a product of modernity and attendant processes of professionalization (Leys, 2000). As a result, the term cannot fully be understood in relation to impacted individuals alone; rather, trauma manifests both materially and in consciousness as a produced cultural effect. In developed nations lifetime exposure to "traumatic" events has been estimated at 50-60%; in developing and war torn nations, the figure rises as high as 92% (de Jong et al., 2001). While not all exposure to "trauma" results in a PTSD diagnosis, global figures suggest that from 13% to 40% of individuals experiencing trauma will meet criterion for a diagnosis, depending upon the toxicity of the traumatic event. Acts of interpersonal violence, including rape, are amongst those events labeled as most toxic, and consequently the likelihood of a PTSD diagnosis increases for those experiencing such acute traumatic events compared to those exposed to other forms of trauma (Norris & Slone, 2007). Although gender may more realistically be conceptualized as a "proxy" variable, findings suggest that following exposure to trauma, women are more likely to develop PTSD than men (Kimerling, Ouimette, & Weitlauf, 2007). Because a PTSD diagnosis launches a range of prescribed approaches that function together in ways that resemble a social "machine" with investments in the status quo, a targeted subject learns to monitor herself and her relations, sometimes in infantilizing ways. Social competence can thus be undermined, while actively shared interventions in the socio-political causes of trauma may fall from view, as collateral damage. In a medicalized context, incentives emerge for clients and professionals to adopt increasingly commercialized approaches to healing. Finding a balance between the relief afforded clients, who need helpful ways to interpret disconcerting but comprehensible responses to violence, and refusing loss of critical attention to the social production of "discontents," requires more powerful interdisciplinary commitments to understanding the broad

determinants of health. This paper argues that the dominant medical model promoting a PTSD diagnosis, by paradoxically normalizing and pathologizing the aftermath of violence, obstructs deeper understanding of how individuals make meaning from their complex lives. Perhaps the larger travesty lies in how a PTSD diagnosis works to derail progressive social and political discourses currently informing understandings of violence against women specifically and against humanity generally.

**Gordene MacKenzie, Merrimack College. "Whose Disorder: Gender Identity Disorder and Cultural Warfare"**

Gender Identity Disorder (GID) – a mental disorder applied to persons whose gender identity and/or expression do not conform to their assigned birth sex – first appeared as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. Appearing as two new disorders, "Gender Identity Disorder of Childhood" and "Atypical Gender Identity Disorders," this new class of disorder appeared just as "homosexuality" was being removed from the DSM. These diagnoses are utilized by affirming care providers to facilitate access to hormonal and/or surgical transition, which for some can be a "matter of physical necessity." But these two new categories also provided clinicians, researchers, policy makers, and others new power to regulate and stigmatize gender non-conformity.

This paper will address the history of GID and the ongoing cultural war between those who have the power to define what GID is, and those who are harmed and marginalized by the GID diagnosis. In the current DSM-IV-TR, Gender Identity Disorder is categorized with sexual paraphilias, including pedophilia. A new term autogynephilia appears in parenthesis and suggests that transwomen are narcissistically in love with and sexually aroused by themselves, preventing them from forming mature relationships with others. This is part of a theory developed in the 1980s by Ray Blanchard, who is heading the DSM-V committee on Sexual and Gender Identity disorders. A second part to his theory has recently been popularized by Michael Bailey, who argues that all transwomen are either autogynephiles or male homosexuals who desire surgery in order to have sex with men.

Although we have seen gains in anti-discrimination legislation, transgender persons are still disproportionately stigmatized and victimized. Clinicians who are unfamiliar with the nuances of a transpersons' frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief or experience that are particular to transgender culture. The use of such diagnoses by the chair of the GID work group to recommend reparative



therapy for young gender non-conformists is cause for serious concern. Scholars, clinicians and transgender activists argue that such therapy is extremely punitive and harmful to young gender non-conformists. The appointment of such “authorities” to high positions threatens to roll back progressive gains. A petition “Objection to the DSM-V Committee Members on Gender Identity Disorders” is being circulated worldwide and has nearly 10,000 signatures.

In addressing the cultural war that is occurring between advocates of the GID diagnosis and opponents, I will include extensive interviews I have conducted with transgender researchers and activists, including Dr. Kelly Winters, the founder of GID reform movement. Finally I will discuss the implications for treatment, including the care of transgender children who are coming out earlier and demanding hormone blockers to delay puberty.

**Joseph Mancuso, University of Waterloo. “Controlling the Body: The History of the Gym”**

In *Madness and Civilization* Michel Foucault suggests that, “Civilization, in a general way, constitutes a milieu favourable to the development of madness. If the progress of knowledge dissipates error, it also has the effect of propagating a taste and even a mania for study; the life of the library, abstract speculations, and the perpetual agitation of the mind without the exercise of the body can have the most disastrous effects.” In Foucault’s thesis the disastrous effects of the inactive body are a necessary repercussion of academic atmosphere in which the mind is favoured over the body. Today this phenomenon has extended into the new information/technology-based economy where jobs require specialized fields of knowledge. The demands of the modern economy force the body to be inactive, creating an atmosphere for madness and a variety of ‘disorders’ from depression to general anxiety. In a society where a myriad of prescriptions are readily available to a catalogue of disorder, a return to a focus on the body is becoming a more viable measure of ensuring mental and physical health.

Throughout Foucault’s scholarship, control of the body through physical labour is revealed to be the cure of both madness and crime. Within the institutional context it functions to both prevent and correct criminal and neurotic behaviour by reintegrating the patient as a functional member of society. In a broader context the gym has become the answer to the problems created by the modern economy. In a world where the body has been abandoned and forgotten, the gym offers a space dedicated entirely to the body. Though this space seems to be a realm of the physical, it is through manipulating the body that the mind receives the proper balance of chemicals it requires. A

historical analysis of the corporate and institutional gyms will reveal how it has been organized and shaped by the modern economy to become a functional mechanism for dissecting, labelling and controlling the body, while fighting an array of disorders that are related to the mind.

**Mary Marcel, Bentley College. "Pseudo Love: Pedophilia and Ephebophilia as Corrupt Psychological Terms"**

This paper interrogates the DSM terms pedophilia and ephebophilia and contends that DSM language should minimally be changed to *pedosexual* and *ephebosexual*.

The classical Greek morphological ring of pedophilia and ephebophilia lends them undeserved and unscientific clinical legitimacy. These modern terms for disorders of adults who are sexually interested in children or adolescents go beyond mere description. They stipulate the quality of the relationship, but only from the standpoint of the adult perpetrator. *Pedophile* makes the perpetrator of child molestation and rape a "lover of children." *Ephebophile* makes a perpetrator of the rape and molestation of underage adolescents a "lover of adolescents." The use of the term "philia," one of three Greek words for non-sexual love, both cloaks the sexual interest, and urges us to accept the adult's version of how the child may feel about the sexual contact. The perpetrator "loves" that child, against any clinical and social evidence that the child does not experience the attention that way.

Among historical Greek man-boy relationships, which these -philia terms disingenuously evoke, the terminology was much more honest. The Greek term for man-boy relationships was *pederasty*, where "ped" refers to the child and "erast-" refers to the erastes, or adult male who pursues an adolescent youth. The relationship, eventually with legal stipulations, involved a multiplex and ritualized relationship. The erastes had to gain permission from the father as well as the son; give the boy, his family and friends certain gifts; take the boy to the wilderness for a few months to teach him the arts of chariot-driving and hunting; and give a feast upon the couple's return.

Most importantly, *the suitor had to receive both the boy's and his father's permission first before initiating the relationship*. The boy, or eremenos, was protected by law and custom against most kinds of sexual contact from the erastes, particularly anal penetration. Such relationships were in the public domain, and adult men who violated their tenets could be prosecuted.

The second point concerns the conflation of sex, love and power in the terms ephebophile and pedophile. The modern terms heterosexual,

homosexual and bisexual (first coined in the twentieth century) simply connote a vector of sexual desire. They do not prescribe anything about the emotional or power dynamics of a relationship. Thus, those terms may entail mutually satisfying sexual relationships; abusive ones; casual ones; or denote rape, as in “heterosexual rape.” If children are recognized as a pathological vector of sexual interest in adults, the disorder should be named to reflect the vector of desire, rather than imputing an adult-centric, self-justifying and usually wishful version of the *separate* quality of the relationship as experienced by the child.

These terms facilitated shifting blame onto girls in the priest sex crisis. Dozens of women abused from ages six and up report being asked why they “seduced” the priest. Making a child the adult’s equal simply erases her psychological damage and exculpates her abuser.

**Anne McGuire, OISE-University of Toronto. “Representing Autism: A Sociological examination of contemporary Conceptions of Autism in Advocacy”**

Drawing on recent work in the field of disability studies, this paper examines the political and social dimensions of contemporary perspectives on Autism Spectrum Disorders. The notion that autism is an individual ‘disease’ of ‘epidemic’ proportions is being achieved, not only by the medical sector, but also, in part, by autism advocacy organizations – organizations that are chiefly comprised of non-autistic individuals charged with advocating for and supporting autistic people. This paper will chart the development and cultural significance of a marked change in how autism is being represented by mainstream advocacy groups – organizations are shifting away from representing autism as a disability (with subsequent claims to access and accommodation), instead representing it as a disease that requires treatment and/or cure. This paper is interested in the discursive trope required to construct autism as a ‘disease’ in need of ‘cure’ as this contrasts with competing conceptions of autism as a disability category with rights and claims to acceptance and access. As an example of this move toward representing autism as a disease, a 2008 information package for *Walk Now for Autism*, an *Autism Speaks Canada* fundraiser, appeals for donor support by stating that autism is more common than “AIDS, diabetes and cancer combined.” Similarly, the Autism Society of Canada states that Autism Spectrum Disorders are “more common than multiple sclerosis, cystic fibrosis and childhood cancer.” The linguistic shift away from autism as a disability category and subsequent movement towards conceiving of autism as a disease significantly influences how autism is imagined in contemporary times. Discursively characterized as synonymous with life threatening illness and disease, autism gets taken up as something that must be first targeted (for

example, the US congress' "war on autism") and subsequently "stopped", "treated", "cured", "eliminated", "eradicated". Indeed, linguistic demarcators like "Think Autism. Think Cure" and "Defeat Autism Now!" produce and sustain harmful beliefs that the autistic life is a "non-viable" life (Butler, 2004).

Yet, alternative relations to, and expressions of, autism exist. As many autistic activists and scholars have articulated, autism is not simply a disease that requires a cure. Jim Sinclair contests the disease/cure model of autism by stating: "[Autism is] a way of being. It is *pervasive*; it colors every experience, every sensation, perception, thought, emotion, and encounter, every aspect of existence. It is not possible to separate the autism from the person--and if it were possible, the person you'd have left would not be the same person you started with." (Sinclair, 1993). This paper asks: what are the social, political and even ethical consequences of conceiving of autism as some-thing that some people have, and as such as something that can (or at least ought to be) eradicated? Moreover, by attending to the ways autism is taken up in contemporary times, how might we reflexively challenge and strengthen our work of non-autistic advocates, service providers and other potential allies of the autistic community?

**Robert McRuer, George Washington University. "No Future for Crips: Disorderly Conduct in the New World Order"**

In *Terrorist Assemblages: Homonationalism in Queer Times*, Jasbir K. Puar examines the production of a range of neoliberal queer subjectivities. Focusing on global processes of what she calls "incorporation" and "quarantine," Puar contends that the biopolitics of Empire now target certain lesbian and gay, and even "queer," subjects for life while simultaneously queering "terrorist corporealities" and targeting them for death. The latter side of this binary is always and everywhere marked as "disordered," while the former has been increasingly, over the past few decades, detached from discourses of disorder and dysfunction. Puar understands the queer processes of incorporation and quarantine as deeply related: "the deferred death of one population recedes as the securitization and valorization of the life of other populations triumphs in its shadow." In "Disability Nationalism in Crip Times," I extend Puar's analysis, considering—through an overview of queer postcolonial and transnational theory and through readings of Victoria Brittain and Gillian Slovo's play *Guantanamo: Honor Bound to Defend Freedom* and the disability documentary *Murderball*—how a similar but perhaps far more insidious process is at work around impaired bodies.

The Disability Rights Movement has largely spoken to, and on the terms of, the contemporary nation-state, perhaps more than any contemporary liberation movement. This is perhaps not surprising given the ways in which, as Sharon L. Snyder and David T. Mitchell explain it, the twentieth century has been characterized by the transnational sharing of ideas about how each nation-state might better “manage” its disabled population (the nation-state, in other words, has been a prime site for generating discourses of disorder and has managed the “crisis” by sharing strategies for controlling it). Faced with such “management,” people with disabilities spoke back to the state and contested and revised its understanding of disability. As the century ended, some people with disabilities increasingly found themselves incorporated into the nation, with the Americans with Disabilities Act standing as one of the premier documents testifying to this always-partial and incomplete incorporation. This paper contends, however, that certain impaired bodies, not legible within those identity-based and nationalist terms, are always positioned, or indeed produced, outside the nation and state and are, like the corporealities Puar analyzes, marked as disordered and targeted for death. Guantanamo, external and internal to the nation, is a hypostasized site for practices associated with what Michelle Brown and others have called “the prison nation,” and is one location where these crip processes of incorporation and quarantine might be considered. Brown argues that “the sparse amount of research that addresses the psychology of supermax confinement provides evidence for increased problems with concentration, thinking, impulse control, and memory, as well as the development of severe anxiety, paranoia, psychosis, depression, rage, claustrophobia, and hallucinations.” My reading of *Guantanamo* traces why such impairments are not comprehensible as “disabilities” and argues in the process that they mark the limits of both the nation-state and disability movements that are largely seeking inclusion in it.

**James Overboe. Wilfrid Laurier University. “Affirming ‘Disorderly Conduct by Applying Post-structuralist Theory to a Life”**

From the perspective of various poststructuralist theorists including Giorgio Agamben, Michel Foucault, Judith Butler and Gilles Deleuze this Auto-ethnography illuminates a life of “disorderly conduct” in body and mind. Moreover, drawing on the work of Foucault this essay excavates how the medical discourse through clinical diagnosis imposed the category of disability (and more specifically the interpellation of cerebral palsy) upon me. Judith Butler’s theory of performative acts brings insight to how the subordinate discourse of rehabilitation along with the parent discourse of medicine supplant my lived experience with a “disembodied” self laid out in medical and rehabilitation records buttressed by the belief in the notions of rational discourse and

progress associated with modernity. My lived experience was straitjacketed by the identity of cerebral palsy

According to Zygmunt Bauman we are situated on the cusp of modernity and postmodernity where the former is authorized by legislators and the latter by interpreters. I detail how the orthopaedic surgeon the legislator had the power to declare that I was incapable of “overcoming” my cerebral palsy and in fact could not be considered within the spectrum of cerebral palsy. In his analysis of Hannah Arendt, Giorgio Agamben considers the undecideability of being a refugee without status or identity. In the same manner, I explore how my status and identity of disability along with my being an “unreasonable facsimile” of able-ness left me adrift. Drawing on the work Deleuze I end the essay by affirming life expressed as “disorderly conduct”.

**Daniel Patrone. Union Graduate College Mt. Sinai School of Medicine. “Suffering, Controversial Choices, and Persistent, Contentious Disorders”**

*Morgellons* is a controversial new diagnosis in which patients report sensations of biting, stinging, and crawling on and in their skin, and often they scratch themselves to the point of creating sores. Paradigmatic of this condition is (1) a belief that there are bugs or, more commonly, threads or fibers growing out of the lesions and on or under the skin, and (2) patient collection of samples of materials from their skin as “proof” that the patient is being misdiagnosed as delusional, the so called “Matchbox sign.” *Body Integrity Identity Disorder* is a controversial new diagnosis in which patients report only being able to feel “whole” or “themselves” with the removal of an otherwise healthy limb. These patients commonly seek amputation, self-amputate, or damage limbs sufficiently such that surgeons are forced to amputate. In both disorders, sufferers strongly resist the traditional medical characterizations of their conditions as psychiatric disorders

Given the unusual nature of the refusals and requests of their sufferers, these disorders present tremendous challenges for the place of autonomy in medical ethics. Where patients suffer from contentious and poorly understood disorders, how ought we to think about patterns of controversial patient preferences and their relations to underlying contentious disorders?

Most philosophical attention to these particular illnesses focus on explaining how new psychiatric disorders emerge and proliferate. But this prematurely presupposes that there are, in fact, psychiatric disorders to be explained. Attention to questions of pathology in ethical discussions has obscured the important fact that, delusional or not, these patients experience tremendous “*secondary suffering*” –

frustration, anguish, and aggravation born of the long experience of what they perceive to be persistent and callous misunderstanding and a medical community willing to provide only ineffective or inappropriate treatment. This secondary suffering often becomes central to the patient's identity and self-narrative. If secondary suffering can distort the evaluative process, then it is possible that, independently of pathological influences, the experience of a long-term and poorly understood illness in general can give rise to questions about the decisional capacity of patients and can, in part, offer alternative, non-psychiatric explanations of their unconventional refusals of care and requests for controversial treatment.

Drawing on the work in cognitive science of Tversky, Kahneman, and others, I examine the effect that secondary suffering may have in the evaluation of evidence and in subsequent deliberations. Though the relevant findings of cognitive scientists have been widely recognized in research science, insufficient attention has been paid to the ways in which they may bear on reasoning in the clinical setting. But this should be of interest in healthcare contexts since, in these crucial cases, (1) they help to explain why seemingly competent decision-makers may persistently resist medical evidence or show preference for alternative or unusual treatments, (2) they shed some light upon how we ought to evaluate certain positive reports regarding the efficacy of controversial treatments, and (3) they can actually help to ameliorate some of the difficulties contributing to the controversial nature and poor understanding of such disorders.

### **Christopher Riddle, Queen's University. "Disorders, Disability and Equality"**

While there has recently been a great deal of activity attempting to mend what is perceived as the human right of "the right to health" to considerations of distributive justice, classical theorists nevertheless remain at least partially committed to the view that all agents with a claim to distributive resources are roughly equal in various capacities.

This paper critically engages with the notion of 'disorder' to effectively examine the scope of contemporary egalitarian theorizing. Conceptions of justice have often relied upon what I view to be overly simplistic conceptions of health and disability. I argue that if we expand our notion of 'disorder' beyond a simplistic medicalized conception, that we can begin to take questions of justice and disability seriously.

This paper proceeds by advancing two interrelated arguments against the capabilities approach of egalitarian justice. Prior to presenting these arguments, I begin with a brief discussion of the capabilities approach as

conceived of by Nussbaum, and examine what this conception claims to do for the experience of disability. I then move to the first of two objections focused on the so-called indexing problem - how to identify the least advantaged within a pluralistic conception of well-being. The first discussion highlights both the difficulty, as well as necessity of ranking or ordering capabilities. This consideration is then complimented by the introduction of a previously unarticulated difficulty within the indexing problem. I make the distinction between what I call horizontal spectral analysis (the ordering of a capability amongst other capabilities) and vertical spectral analysis (the ordering of the opportunity or ability to achieve, secure, or perform a particular capability distinct from considerations of the relationship to other capabilities).

Ultimately, I conclude that despite the recent wealth of theorizing surrounding Martha Nussbaum's capabilities conception of social justice, the full inclusion of people with disabilities is not, and indeed cannot, be promoted under the guise of such a conception. I arrive at this conclusion for numerous reasons, but the most note-worthy is perhaps because of the lack of consideration paid to the notion or scope of 'disorder'. Disability as an experience remains under theorized. I argue that it is not until we begin to clarify and expand our conception of 'disorder' to assure inclusiveness, that a theory of justice for health can begin to take seriously the notion of disability or disorder.

**Heidi Rimke, University of Winnipeg. "Disordering Subjects: Psychocentrism, Resistance, and the Normative Construction of Disorder"**

Arguing that the historical advance of a pathological model of conduct was consistent with the historical formation of the social and political rationalities of capitalism, the paper examines the normative construction of 'disorder' in Western psychiatric discourses. To do so, the paper begins by discussing the origins of conduct disorder as rooted in the nineteenth century doctrine of moral insanity aimed at governing 'ungovernable,' dangerous, or otherwise problematic conduct. Claiming that psychocentrism, as the cultural corollary of neo-liberalism, was necessary in attempts to govern what was viewed as an increasingly disorderly population, the paper will chart and analyze the ways in which different forms of human resistance have been, and continue to be, pathologized in Western medical texts, thus highlighting the political and cultural functions of psychiatric discourses. Finally, the paper concludes by offering a framework to critique and resist the compulsory ontology of pathology characteristic of modern subjectivities.



**Katrina Roen, University of Oslo. "Variant Clinical Discourses: Problematising the Conceptual Foundations for Clinical Interventions with Gender Variant Youth"**

CGID is a highly contentious 'disorder' whose definition and treatment continue to be debated and reshaped. The present paper works with the disjuncture between clinical understandings (that gender variance constitutes disorder) and queer understandings (that gender variance is to be welcomed), in order to critically examine the diverse clinical responses that are now emerging in relation to the treatment of CGID.

Treatment of CGID occurs in the context of wider societal changes in understanding about how 'gender identity' is supposed to be expressed. When the concept of gender identity was explicated by early contributors to the field, it was commonly understood that gender identity operated within a binary framework, and that promoting wellbeing meant supporting patients to aspire to societal norms constructed within that binary. Now, there are more cultural locations where gender identity is understood as fluid. This offers new ways of thinking about clinical approaches promoting the wellbeing of gender variant youth.

While the possibilities of living between genders, or transitioning from one gender to another, are not commonly welcomed, these possibilities are now recognised to exist. There now exist communities where such possibilities are articulated and promoted. Nevertheless, gender variance still provokes anxiety, inspiring attempts at 'correction.' This has brought criticism when the person concerned is a child or adolescent. Where is the boundary between therapeutic interventions intended to address the child's distress of gender variant young people, and therapeutic interventions intended to address societal anxieties about gender variance? What approach to any such intervention is appropriate? And what counts as a 'successful' outcome?

Different clinics take different approaches to gender-variant children and adolescents. Some clinicians engage therapeutic practices to reduce atypical gender expression. Some clinicians suggest going stealth: encouraging children to hide their gender variance for pragmatic reasons such as to avoid bullying. Some clinicians work with parents and young people to support exploration of intermediate gender possibilities. Some clinicians employ endocrinological interventions, to facilitate a process of gender transition. These approaches are not mutually exclusive but they do give important insight into the discursive terrain we need to understand to analyse contemporary clinical approaches to CGID.

The present paper examines contemporary psychological work with children and adolescents with GID, analysing their conceptual foundations and their implications for young gender variant people. It asks: how might the 'success' of a new treatment approach impact on foundational theoretical understandings about gender identity? Poststructuralist theories of subjectivity and embodiment are drawn on to suggest how clinical approaches might engage with contemporary theorising of gender, rather than reiterating popular and historical understandings that privilege binary gender.

**Lynda R. Ross, Athabasca University. "What Happens When We Start Looking at Relationship "Problems" as Attachment "Disorders"?"**

In the early 1970's only a handful of "attachment" studies had been published; today we see entire scholarly journals devoted to the topic, publishing literally thousands of articles each year (Ross, 2006). Earlier conceptions of the theory focused on similarities between adult and infant styles; inter-generational transmission of attachment styles from mother to infant; and on the continuity of attachment patterns from infancy into adulthood. Typically today's research looks at the mediating and moderating effects of attachment styles and dimensions in relation to a host of other psychological and psychiatric variables (e.g., Shaver, Collins, & Clark, 1996). Relational research uses attachment orientations to help explain individual differences in partner selection, break-up rates, and in some instances to help explain abusive romantic partnerships. Attachment orientations are also used to predict the quality of intimate romantic relationships and to link the mediating and moderating roles of child and adult attachment "styles" to psychopathology (e.g., Bowlby, 1989; Davila, Steinberg, Kachourian, Cobb, & Finchman, 2004; Gentzler & Kerns, 2004; Gratz, Conrad, & Roemer, 2002; Holmes, 2003; Myhr, Sookman, & Pinard, 2004; Schachner & Shaver, 2004).

Complex relational problems, once thought of as difficult, problematic, or perhaps even dysfunctional, are now being described as "attachment disorders." Not only does this approach have little empirical grounding, it also implies that for those experiencing relationship difficulties, the "problem" is located in the individual rather than in the context or dynamics of the relationship. While "attachment disorders" do not, at present, form part of the DSM nosology; a special case -- reactive Attachment Disorder (RAD) -- does. RAD made its first appearance in the *Diagnostic and Statistical Manual of Mental Disorders'* nosology in 1980 (DSM-III: American Psychiatric Association). Its inclusion was a response to findings from a sparse literature that focused on institutionalized children and their experiences of severe maltreatment and extreme deprivation. In its earliest iterations, the disorder became synonymous

with “maternal deprivation,” a term introduced by Spitz (1945) in his work with “foundlings” and later popularized by Bowlby (1951, 1952, 1958). Recognized as a “disorder of mothering,” the disorder was commonly linked to poor mothering skills or maternal psychopathology (Derivan, 1982; Evler, 1985; Tibbits-Kleber & Howell, 1985). Still only a handful of case studies have been published assessing the impact of severe deprivation during early childhood development (Chisholm, 1998; Iftene & Roberts, 2004; O’Connor, Bredenkamp, Rutter, et al., 1999; O’Connor, Marvin, Rutter, et al., 2003; O’Connor & Rutter, 2000) and there are fewer studies reporting the effects of maltreatment of noninstitutionalized children (Heller, Boris, Fuselier et al., 2006; Newman & Mares, 2007; Skuse, 1984a, 1984b; Solomon & Peltz, 2008). While two distinct forms of RAD have been defined in the DSM, there is not enough substantive evidence to justify the division.

This paper reviews the historical development of the attachment construct and discusses concerns about using this construct as the basis for defining “disorders.” The discussion will focus on the impact of a “disorders” perspective in trying to understand a child’s “healthy” adaptation to difficult circumstance as well as to its impact on contemporary notions of motherhood.

**Stephanie Speanburg, Emory University. “Fine Lines Carved in Flesh: Delineating Subversion from Submission in Gender, Borderline Personality Disorder”**

The proposed paper interrogates the relationship between the socio-clinical construction of Borderline Personality Disorder (BPD) and the interpersonal subjective experience of women diagnosed with this complex disorder. Rather than recapitulate feminist critiques of psychiatry which founder in the logic of social determinism, my approach queries how such constructions interact with individual biological and psychological endowments, life events, and relational experiences, and thus, how social-clinical constructions can become interior processes. In so doing, I will raise larger theoretical questions about gender, subjectivity, and suffering.

Over the last three decades, Borderline Personality Disorder in women has preoccupied American psychiatry. Defined as a persistent pattern of marked disturbance in identity, chaotic relationships, and affective instability, BPD is diagnosed when an individual repeatedly exhibits intense anger, uncontrollable anxiety, impulsive, and self-destructive behavior that often escalates to self-mutilation and suicide attempts. Before the appearance of Borderline Personality Disorder in the DSM-II, Deutsch (1942) observed an “as-if” quality to subjective experience in some of her woman patients and that their chaotic behavior and

emotional distress was more apparent to others than themselves. Although there is an “amorphous” quality to the subjective experience of the Borderline, descriptive diagnoses (offered by the DSM-IV and proposed by Gunderson) and likewise, psychodynamic structural diagnoses (suggested by Kernberg and other psychoanalysts) attempt to make concrete what is mysterious and escapes the Borderline’s own articulation. While diagnosis brings the clinician’s experience of the borderline woman to language, the diagnosis, “is an empty signifier to the Borderline woman” (Fromm, 1995). Thus, the diagnoses speak more about the clinician’s intellectual and affective experience than they do about the perspective of the BPD woman herself (Fromm, 1995). Diagnoses reflect an approach that treats an object (BPD) rather than a person, and do not bring us closer to understanding the gendered language about a self that the Borderline woman struggles to articulate.

By contrast, I take seriously both the subjectivity of the Borderline and the clinical context within which she is simultaneously diagnosed and produced. I begin by arguing that the intersubjective matrix constructed between clinician and patient in fact ignites many of the borderline’s symptoms. The expression of contradictory self-images, self-mutilation, diffuse anxiety, and intense rage characteristic of BPD emerge in the context of power, and hierarchical relationships, especially that between clinician and patient. Further, in her violence against her body, her inability to articulate trauma or to verbally express affect, and her defiance of unitary self-presentation, the Borderline performs a unique form of subjectivity whose gendered dimensions are crucial. This focus on gendered subjectivity within a two-person matrix produces several theoretical questions that my empirical research will attempt to answer: What does the Borderline’s action and language reveal generally about the gendered structure of subjectivity. Does the Borderline’s violence to her body articulate a specifically feminine form of struggle? Does this self-directed feminine violence repeat and re-enact violences done to her by men, language, and culture? Why are women as much as four times more likely than men to be diagnoses with Borderline personality disorder? Finally, what does borderline discourse communicate with respect to sexual difference and power, particularly in relation to psychiatry?

**Bethany Stevens, Morehouse College School of Medicine and Sunny Nordmarken, Georgia State University. "Queer Corpo(realities) of Transgender, Intersex, and Disability: Towards a Coalitional Politics for Bodiosexual Justice"**

Contemporary culture assigns meanings of "abnormal," "undesirable," and "defective" to disability, transgender, and intersex bodies – bodies that queer corporeal norms. People who inhabit these "queer bodies" experience corporeal oppression on social, structural, and psychological levels. Institutionalized exclusion, social policing, and medical invasion remake stigmatization and dehumanization of queer bodies. Institutions of ablebodiedness, gender, and compulsory normative sex and genitals collaboratively construct unattainable illusions of normativity, invade and mutilate our queer bodies. Though transgender, intersex, and disability people are all hurt by the imaginary concept of body normalcy, many of us continue to only fight for our specific group's rights. Acknowledging that each group is a numerical minority, we insist on a coalitional politics to create an alliance for corporeal justice. This paper draws on frameworks of sexual health, human rights, queer theory, and crip theory to re-humanize and reframe body queernesses as sites of humanity, agency, solidarity, and resistance.

**Jijian Voronka, OISE-University of Toronto. "Disorderly Diagnosis: Resisting Psy Comprehension through the Media Case File of Britney Spears"**

This paper explores media representations of Britney Spears as she came to be understood as a psychiatrized subject through the press in 2008. Through an analysis of 'lay' popular magazines, I explore how the troubling of Britney Spears' disorderly conduct was 'made sense' by drawing on psychiatric expertise and clinical diagnoses in such texts as *People Magazine* and *Us Weekly*. Drawing from disability studies and feminist poststructural frameworks, I argue that the project of medicalizing Britney Spears' disorderly behaviour works towards solidifying biomedical conceptions of disorderly conduct. Importantly, I look at the ways in which images and text in 2008 tabloid presses have worked to disperse psy discipline diagnoses to 'lay' tabloid readers. I will show 1) the ways in which psychiatric expertise has been brought into the tabloid press in order to explain Britney's history of disorderly behaviour, and promote psychiatric understandings of madness. 2) How information on signs and symptoms of mental illness have proliferated in tabloid text, and how this data can be used to psycho-socialize and instil order in the lives of everyday readers. 3) How the media monitoring through paparazzi photography of Britney's life is similar to case file clinical monitoring. I explore how these thematics work to provide comprehension to disorderly behaviour, as well as invites the

public to draw on psy diagnoses and incorporate them into their daily understandings of individual and social disorder. Ultimately, I explore how media reporting and diagnosing of Britney Spears has worked to teach the public how to approach, diagnose, treat, comply, struggle, and recover from mental illness. In this way, the story of Britney as told through the press has worked to teach readers the appropriate biomedical methods of how to make disorder orderly.

But, as always, there is room for resistance within these media accounts. In their struggle to make sense of Britney's disorderly conduct, the plethora of psychiatric experts that were consulted by the media to account for Britney's 'disruptive' behaviour resulted in a diagnostic war: in the early months of 2008 alone, she was theorized as having bipolar disorder, histrionic personality disorder, addiction disorders, schizophrenia, and multiple personality disorder (Voronka, 2008: 9-11). I want to approach this diagnostic war as a space where dissent can struggle to power: that the conflicting and competing diagnoses that were attributed to Britney can work to destabilize the certitude that biomedical understandings of disorderly conduct promote. Further, that this diagnostic competition reveals conflict that is often mirrored in the everyday experience of psychiatrized people as we travel through various psy architectures of understanding ourselves. Ultimately, I ask, when absorbing these conflicting accounts of Britney's disorders, to think through how this incomprehension is similar to the everyday experiences of the psychiatrized as psy disciplines work to diagnose us: a mass of discontinuity, uncertainty, prediction – and ultimately disorder. And when there is made room for rupture, therein lies the possibility of resistance, and the beautiful “promise of thinking and doing otherwise” (Lather, 2007: 13).

**Samantha Walsh, OISE-University of Toronto. “My Personal Trainer and My Culture Want me to Walk More: Disability, Gender, and the Healthy Body”**

The overall topic of the paper is a discussion of the paradoxical social positioning of the healthy body with the disabled body. The tension the paper seeks to draw out is the notion that while the disabled body may exist in everyday life, and participate in health rituals it is not perceived as “healthy”. The paper opens with the narrative of a trainer implying to the author (a disabled woman) that to be healthy and attractive she should take on an embodiment that walks. The paper continues with the interrogation of this narrative exploring concepts of how disability troubles main streams perceptions of the body as theorized by ; the Foucauldian (1977) notions of the gaze and self surveillance, as well as Butler (1990)'s discussion of gender performance. More over the paper employs a disability studies perspective as it is animated by the writings

of Garland-Thompson (1997), Clare (1999), McRuer (2002), Michalko (2002) and Titchkosky (2003) In drawing on these theories, the paper is able to place the narrative not as an awkward interpersonal moment, of tension and attempted erasure of disability. Rather the moment, is a microcosm of a culture which is made awkward by its attempts to construct a bodily ideal which excludes an embodiment that is temporal. Every member of society migrates in and out of disability at some point, therefore to continue to exclude the disabled body perpetuates an ideal body and an "othered" body.

## **Thank You!**

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