

10-1-2015

Agonizing Identity in Mental Health Law and Policy (Part I)

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Recommended Citation

Sheila Wildeman, "Agonizing Identity in Mental Health Law and Policy (Part I)" (2015) 38:2 Dal LJ 619.

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In this two-part paper, the author explores the significance of identity in mental health law and policy. In this as in other socio-legal domains, identity functions to consolidate dissent as well as to effect social control. The author asks: where do legal experts stand in relation to the identity categories that run so deep in this area of law and policy? More broadly, she asks: is “mental health” working on us—on the mental health disabled, legal scholars, all of us—in ways that are impairing our capacity for social justice? In the first part of the paper, the author considers the Foucauldian exhortation to undertake a “critical ontology of ourselves” and asks what it would mean to take this curious exhortation personally, with regard to one’s mental health. In the second part, which will appear in the next issue of the Dalhousie Law Journal, she builds out from these insights toward a political taxonomy of mental health identities.

Dans cet article en deux parties, l’auteure examine l’importance de l’identité dans les lois et les politiques en matière de santé mentale. Dans ce domaine, tout comme dans d’autres domaines sociojuridiques, l’identité sert à consolider l’opposition et à exercer un contrôle social. L’auteure demande où se situent les experts en droit par rapport aux catégories d’identité enracinées si profondément dans ce domaine du droit et de politiques? Plus généralement, elle veut savoir si la santé mentale nous influence-t-elle – les handicapés mentaux, les juristes, nous tous – de façons qui nuisent à notre capacité de justice sociale? Dans la première partie de l’article, l’auteure examine l’exhortation de Foucault qui nous incite à entreprendre une « ontologie critique de nous-mêmes ». Elle demande ce que cela pourrait signifier, par rapport à la santé mentale de chacun, de prendre personnellement cette étrange exhortation. Dans la seconde partie, qui sera publiée dans le prochain numéro du Dalhousie Law Journal, elle s’inspire des réponses à ces questions pour s’orienter vers une taxonomie politique des identités en santé mentale.

* Schulich School of Law, Dalhousie University, Halifax. Special thanks to Kim Brooks for organizing the Identity Workshop and for editorial assistance, and for being Kim Brooks. Thanks also to the two anonymous reviewers of this paper, and to Colin Jackson, Jarod Cedor, and the other participants in the workshop.

Introduction

- I. *Autoethnography (in a mad, mad, mad, mad world)*
 1. "... an expert in the area of mental health law and policy"
 2. *Pinned*
 3. *Phantasms (the spectral / between worlds)*
- II. *Toward a political taxonomy of psychiatric subjectification*

The critical ontology of ourselves must be considered not, certainly, as a theory, a doctrine, nor even as a permanent body of knowledge that is accumulating; it must be conceived as an attitude, an ethos, a philosophical life in which the critique of what we are is at one and the same time the historical analysis of the limits imposed on us and an experiment with the possibility of going beyond them.¹

What we are dealing with in this new technology of power is not exactly society (or at least not the social body, as defined by the jurists), nor is it the individual-as-body. It is a new body, a multiple body, a body with so many heads that, while they might not be infinite in number, cannot necessarily be counted. Biopolitics deals with the population, with the population as political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem.²

Introduction

Two puzzles inform my inquiry in this two-part paper. These puzzles express different dimensions of a problem posed (or one I take to be posed) in the work of Michel Foucault: the problem of doing critique, or hazarding a "critical ontology of ourselves," in the thick of biopower. I have encountered these puzzles in theory and in practice, both in my work as a scholar in the field that is "mental health law and policy" and in the work (or work-in-progress) that is myself.

The first puzzle is a methodological one: that of reconciling recognition of the colonization of identity—specifically, in my area of inquiry, the apparently inexhaustible colonization of self and world by the shifting and expanding categories of psychiatric knowledge/nosology—with the project of identity critique registered in the still new, still resonant imperative stated by Foucault in his reconceptualization of oppositional political inquiry: the imperative, already cited, of undertaking a "critical ontology

1. Michel Foucault, "What is Enlightenment?" in Paul Rabinow & Nikolas Rose, eds, *The Essential Foucault: Selections from The Essential Works of Foucault, 1954–1984*, translated by Catherine Porter (amended) (New York: New Press, 1994) 43 at 56 [Foucault, "What is Enlightenment?"].

2. Michel Foucault, "17 March 1976" in Mauro Bertani & Alessandro Fontana, eds, *"Society Must Be Defended": Lectures at the Collège de France, 1975–1976*, translated by David Macey (New York: Picador, 2003) 239 at 245.

of ourselves.” This imperative, as it is transmitted through Foucault’s life’s work, is not, as I understand it, a remote or abstract one: it is a call to bring critique so close to the bone that it pierces one’s contemporary and constructed (still raw and felt, still “personal”) human soul.

Foucault’s imperative embraces the riddling labours of subjecting what is given, or what has acquired the inert and unquestioned status of ontology—that which is fundamental to human being—to the critical and analytical, political self-consciousness of human becoming. But how, exactly, does one adopt the posture of critique when one is strung along the filaments of the given; when one (one’s thoughts and desires, the thoughts and desires registered now on this page and now as I edit this page, and again) occupies a node or perhaps multiple, interactive nodes in the webbing of contemporary historical-political consciousness; when one is so deeply coded and iterative as to encode even the iterative moves of critique? For Foucault (or one of the Foucaults), the critic’s trick is genealogy: creating an oppositional consciousness through attention to the ways that the categories through which we understand ourselves have been created and shaped over time. The payoff, we are told, is recognition that this rush of noise we call identity and truth is dizzyingly polyphonic and in motion, rather than singular and unchanging. We contemplate our radical contingency and this we may (tentatively) call our freedom. Of course the engine of identity and truth, Foucault adds, is power. That may subdue our celebrations somewhat.

So far we are barely striking letter A in the ABC’s of critique. One may dimly recall the point when one first encountered this sort of idea in the Foucauldian original or in some other form. Perhaps one sensed a minor shifting of the ground beneath one’s feet, felt in a newly sensory way the localized flow of history and power around and through one—perhaps one was overcome by a sense of exhaustion, anticipating the Penelope-like raveling and unraveling through which one’s life course might or might not begin to exert just a little tension, here and there, across the warp and woof of a bigger set of stories. Or perhaps one was electrified: perhaps one

looked down the page to the concept of “subjugated knowledges”³ and saw in this intellectual link to the oppressed and dispossessed the possibility of a politicized climax of critical ontology, a potential for making a direct connection between political and social theory and the rising clamour from the prisons, the asylums, the public housing piles. Perhaps one heard the whisper of a kind of electrified clamour from within oneself.

The inquiry I undertake here seeks to simulate that starting-point of critical discernment. I ask: who am I, which is to say, where do I stand among the potent strands of psychiatric and legal knowledge and the politics that sustain and shape that knowledge; where do I stand in the scholarly and also the lived, embattled domain of “mental health law and policy”? The puzzle of reconciling colonization of identity with identity critique is inherent to this question. Of course, a similar puzzle is encountered across the many intersecting fields of identity-based political and social inquiry. And yet the challenges for each field, and each critical interlocutor, differ. There is, I suspect, no general theorem to show the way forward (or back) once we adopt the premise that the categories through which we identify or are identified (and our responses to those categories—our variable turns upon “the looping effects of human kinds”⁴) make us who or what we are.

3. I remember it as a looking down the page, but the work of critical ontology and that of rescuing subjugated knowledge(s) are dealt with in different papers: the first in Foucault, “What is Enlightenment?,” *supra* note 1, and the second in Michel Foucault, “Two Lectures: Lecture One: 7 January 1976” in Colin Gordon, ed., *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, translated by Colin Gordon et al (New York: Pantheon Books, 1980) 78. On the latter concept, Foucault states (at 81–82):

By subjugated knowledges I mean two things: on the one hand, I am referring to the historical contents that have been buried and disguised in a functionalist coherence or formal systemisation...and which criticism—which obviously draws upon scholarship—has been able to reveal.

On the other hand, I believe that by subjugated knowledges one should understand something else, something which in a sense is altogether different, namely, a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity. I also believe that it is through the re-emergence of these low-ranking knowledges, these unqualified, even directly disqualified knowledges (such as that of the psychiatric patient, of the ill person, of the nurse, of the doctor—parallel and marginal as they are to the knowledge of medicine—that of the delinquent, etc.), and which involve what I would call a popular knowledge (*le savoir des gens*) though it is far from being a general commonsense knowledge, but is on the contrary a particular, local, regional knowledge, a differential knowledge incapable of unanimity and which owes its force only to the harshness with which it is opposed by everything surrounding it—that it is through the re-appearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work.

4. Ian Hacking, “The Looping Effects of Human Kinds” in Dan Sperber, David Premack & Ann James Premack, eds, *Causal Cognition: A Multidisciplinary Debate* (Oxford: Clarendon Press, 1995) 351 at 382.

I am 46. That amounts to nothing much except that it is fixed. Moreover it is not, I suggest, a bad age to take stock: to assemble a few of the loose plot lines from my personal and professional life as one might follow, with that strange mix of dejection and ambition, the cords of the various electronic devices snaking off behind the furniture, the tangle of forces and relationships acting in and through me as a “scholar working in the area of mental health law and policy.” It is not a bad time to consider the political and social constitution—and the normative implications—of the position I have staked out and am staking out in this field.

* * *

The above gesture to normative implications leads to the second puzzle informing my reflections. Or rather, it leads to the conspicuously normative dimension of the puzzle I have just expressed. Here, the question is: what is the point of undertaking a “critical ontology of ourselves”—of hazarding such a project in the thick of biopower? What is the point of examining how “mental health” or “mental health identity” is acting in and through me and through others in this field? In what sense, if any, is this a normative project—by which I mean a moral and political project expressive of a claim about justice?

I have already had occasion to use Ian Hacking’s well-worn phrase, “the looping effects of human kinds.”⁵ The phrase emerged fairly early on in Hacking’s tough-minded efforts to retrofit Foucault into the philosophy of science, and has over time come to inform multiple rich explorations (on Hacking’s part and others’) of ways of being human, including ways of being mad, under particular cultural and institutional arrangements.⁶ Hacking’s ingenious gift has been to transmit the core of historical ontology so meticulously and yet so accessibly: the thesis that the categories constitutive of ways of being human are incessantly in interaction with the human beings who interpret and misinterpret themselves under those categories, as well as the legions of experts who refract and reinterpret both subjects and categories along particular trajectories of knowledge. And yet at the heart of Hacking’s (and perhaps Foucault’s) brilliant renderings of historical ontology would seem to be a profoundly mechanistic social order: a kind of inbuilt responsive regulation. That is, the metaphor of looping effects and the work of attending to those effects over time does not, in itself, yield much guidance with regard to whether or how

5. *Ibid.*

6. See, e.g., Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: Princeton University Press, 1995); Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illness* (Charlottesville, VA: University Press of Virginia, 1998).

it is possible to activate choice and responsibility, and so the normative dimensions of one's critical capacities. (Perhaps historical ontology does not deem the proposition intelligible.) This two-part paper aims to conjoin the project of critical ontology with that of normative reflection, beginning with the localized spaces and moral intuitions of my own life and moving gradually outward.

The normative field in which I situate my inquiry is marked by a concern for justice, or for "social justice"—an ideal that is itself radically open to deliberative contestation. My aim is to explore the function (and dysfunction) of identity or specifically of "mental health identity" as it interacts both with psychiatry and with social justice claims-making. In this the question I pursue is: is "mental health identity" getting in the way of our ability to do (social) justice, in and beyond the arenas of mental health law and policy? Or if it is not simply "getting in the way"—if it is more complicated than that, enabling this politics as well as disabling it—then what exactly is mental health identity doing?

I ask this question of myself and across the diverse sites of what we may call the mental health state.⁷ I do not carve off a set domain of mental health law and policy or restrict my inquiry to a particular institutional or doctrinal corner of that domain. Indeed, here it is important to note that "mental health law and policy" is not, or not exactly, a thing. The term is sometimes used in a diffuse way, to describe any area of law or policy viewed through a "mental health lens"; other times (more often) it denotes a sharper, more precise site or set of sites of medico-legal conflict exemplified by the sites of forcible injection. Thus conventional texts and textbook chapters tend to centre upon involuntary or non-voluntary status and interventions—so, fitness to stand trial along with mental disorder-based excuses and dispositions in criminal law, and in non-criminal contexts, regimes of involuntary hospitalization and treatment. This construction of mental health law and policy around the seemingly perennial clash of individual liberties and paternalism/police powers reflects the central (though not exclusive) concerns of the radicalized social movements organized in resistance to coercive psychiatry, which I take up in the next installment of this essay. And yet "mental health law and policy" may also or alternatively denote a far wider range of legal regimes that do not, or do not necessarily, engage the interest in freedom from coercive state intervention—so, anti-discrimination law, employment law,

7. On integrating into Foucauldian critique attention to both state-based and non-state norms, coercion and discipline, see Ben Golder & Peter Fitzpatrick, *Foucault's Law* (New York: Routledge, 2009).

social assistance law, municipal law, residential tenancies, and so on. On this understanding, “mental health law and policy” affects a far broader swath of persons than those targeted for involuntary interventions: persons whose experience of problems at work, with family, with housing, with poverty, at some point in the course of their interactions with psychiatry and with law come to be identified as “mental health problems.”

My intent here is to frame mental health law and policy in broad terms so as to encompass a range of sites wherein psychiatric and legal knowledge and institutions interact with the varied constituencies of medico-legal subjects who populate these domains. Within this broadly-framed field of state and professional norms and practices, I ask who are the central stakeholders—those positioned as directly affected—and how the positioning of these stakeholders interacts with the construct of identity or “mental health identity.” I ask, too, how my own position as “an expert in the area of mental health law and policy” is comparatively constituted.

The politics of mental health, or of mental health law and policy, is rich territory for exploring the function of identity in social justice claims-making. We (or more specifically, we medico-legal subjects of the global north)⁸ gauge our mental health by examining the contents of our thoughts and our feelings, our cognitive and emotional states, and comparing these against standards of normalcy available in our culture and positioned as the stable baseline of our identity: the strongest motifs in the stories we tell about ourselves. Others similarly impute to us an underlying personal identity against which the presence of mental health conditions, in the form of marked deviations from cultural norms, may be deduced. At the extreme obverse of mental health we may lose our capacity for identity: our capacity to tell a coherent story of the self, to hold a stable set of values or memories, and with this, to assert political, moral and legal agency in a manner others recognize as legitimate.

In my inquiry into the function of identity in mental health law and policy I try not to lose these dimensions coded and experienced as deeply personal (or alternatively as deeply alienating: “not-myself”). Indeed, I suggest that the personal, as it relates to mental health identification, is a site of significant political work. Yet my focus is on the implications of mental health identity for social justice or social justice claims-making. I ask: is our increasing ability to recognize ourselves and others through

8. On the rise of “global mental health” and the associated positioning of nations and citizens of the global south as new and emerging markets for psychiatric subjectification, see Sheila Wildeman, “Protecting Rights and Building Capacities: Challenges to Global Mental Health Policy in Light of the *Convention on the Rights of Persons with Disabilities*” (2013) 41:1 *JL Med & Ethics* 48 at 50.

the categories of mental health disabling our capacity to recognize social injustice? Nikolas Rose has argued that psychiatric knowledge is in incessant interaction with the “autonomiz[ing]” and “responsibiliz[ing]” forces of neo-liberal political economy.⁹ This is to suggest that our experience of self and world through the construct of mental health identity may operate to channel our analysis of social and institutional problems (e.g., self-harm and violence in prisons, poverty, homelessness) to the narrow and manipulable sites of mental dysfunction: individual broken brains. This is part of what I am concerned with in asking whether mental health identity or identification is “getting in the way.”

And yet my inquiry into the field of mental health politics is concerned not only with mental health consumerism, expressive of the joint energies of neo-liberal political economy and psycho-pharmaceutical market expansion, but also with what would seem the opposite pole of this politics: the phenomenon of radicalized psy-subjects actively organizing in resistance to psychiatric subjectification and coercion. Are such radical projects, too—perhaps through the very act of solidarity-building around politicized or radicalized mental health identities—“getting in the way” of social justice? Here I seek to take seriously the post-identity critique of identity politics, i.e., the critique that deployment of a (vulnerable, derided) group identity for the purpose of social justice claims-making may paradoxically reify social-structural patterns of domination and oppression, impair recognition and representation of diversity among putative group members, and obstruct the work of social justice movement-building beyond a highly localized micropolitics. I ask: do these criticisms have any purchase on the radicalized politics of mental health?

It is in light of this complex interweaving of identity and identity critique in the domain of mental health politics that I wish to revive or revisit Foucault’s exhortation to attempt the “critical ontology of ourselves”: to call ourselves, the very conditions of possibility of our “selves,” into question through historically- and institutionally-grounded attention to what makes our ways of being human (of being mad, of being political) possible. The point of the exercise is not to suggest that we could or should ever wholly get past mental health identification in our politics or our laws. Rather, the point (or aspiration) of critical ontology and the related work of “agonizing identity”—at least, the point of my engaging with these constructs here—is to become, or to keep striving to become, better equipped to assess the legitimacy of the norms clustered

9. Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007) at 4.

under the descriptor “mental health law and policy.” Perhaps, too, ever so tentatively, we might begin to imagine alternative ways of organizing the conceptual and institutional bases for distributing power in and beyond the mental health state.

* * *

The first part of this two-part paper broaches the question of identity in mental health law and policy through the method of auto-ethnography, and so with reference to my own participation in (and alienation from) the discourse of mental health. I explore, in light of a few fragments from my narratives of self, some of the ways that my identity as a participant in this field is refracted not merely through the categories of psychiatry but through a range of symbolic and cultural, personal referents and relationships that condition the possibilities for my negotiating mental health identification or non-identification.

The second part, which will be printed in the Spring 2016 volume of the *Dalhousie Law Journal*, builds from these efforts at auto-ethnography to construct what I am calling a political taxonomy of mental health identities, or a political taxonomy of psychiatric subjectification. I distinguish three main categories of identity or identification that I suggest assist in illuminating the complexities of social justice claims-making in the politics of mental health:

1. the category of radicalized psy-subjects (including users and survivors of psychiatry, Mad Pride, and antipsychiatry—constituencies that, in different ways, seek to resist the imbrication of psychiatric knowledge and services with societal oppression and state-backed coercion);
2. the category of mental health consumers (an overarching term for a diverse constituency focused in the main on attaining or improving access to services); and
3. the category of liminal psy-subjects, encompassing the suggestible (those standing at the threshold of psychiatric subjectification) and the spectral (a term I use to describe a transitory state, latent in us all, wherein identity may be contemplated in light of its historical and material bases and yet appreciated as lacking in substance, as phantasmic).

I interject episodically throughout Part II to ask where I stand, so rendering my putatively neutral expert status vulnerable to the competing allegiances and priorities of oppositional, pliant, and liminal psychiatric subjects. Part II, like Part I, thus aims to convey an acute self-awareness of its own (my own) artifice or constructedness.

By the end of the two pieces, I hope to have shown that the critical ontology of ourselves requires a special kind of agonizing. By this I mean to signal a shift from the solitary labours associated with the critical-historical ontologist (who, master detective like, retraces the steps of human becoming by way of evidence on the public record) to a more self-consciously political work done in concert with contemporaneous others. The agonizing I have in mind draws on Chantal Mouffe's "agonistic pluralism,"¹⁰ wherein conflict or contestation is positioned as the defining feature of politics. Mouffe's work is informed by the Schmittian insight that "the identity of a democratic political community"—and with this, the possibility of democratic rights of citizenship—"hinges on the possibility of drawing a frontier between the 'us' and the 'them.'"¹¹ Yet Mouffe's theorization of radical pluralist politics rejects Schmitt's idealized expression of the political in the form of a homogeneous identitarian state,¹² just as it rejects the competing liberal ideal of resolving pluralism in untroubled consensus through the unitary construct of reason.¹³ Against both alternatives, agonistic pluralism promotes an ethic of incessant interrogation of constitutive exclusion: a hyper-awareness of the violence of othering implicit in identity and in politics. In this way, agonism may be understood as a necessary feature of the aspiration toward inclusion or inclusive deliberation. Or this is how I use the term here: as a critical reminder of and rejoinder to the cognitive and social processes productive of exclusion, and in this sense a condition precedent to political legitimacy or to the ongoing effort (never fully realized) to build understanding and public justification across difference. Anyhow it suits me, this agonizing, as it conveys the deep discomfort or angst that comes of self-alienating reflection on one's own (my own) and others' mental health—and so on

10. Chantal Mouffe, "For an Agonistic Model of Democracy" in Chantal Mouffe, *The Democratic Paradox* (New York: Verso, 2005) 80 at 101-103. See also Chantal Mouffe, "Carl Schmitt and the Paradox of Liberal Democracy" in David Dyzenhaus, ed, *Law as Politics: Carl Schmitt's Critique of Liberalism* (Durham, NC: Duke University Press, 1998) 159 at 167-168 [Mouffe, "Carl Schmitt"], where Mouffe writes:

Consensus in a liberal-democratic society is—and will always be—the expression of a hegemony and the crystallization of relations of power. The frontier that it establishes between what is and what is not legitimate is a political one and for that reason it should remain contestable. To deny the existence of such a moment of closure or to present the frontier as dictated by rationality or morality is to naturalize what should be perceived as a contingent and temporary hegemonic articulation of the people through a particular regime of inclusion/exclusion. The result of such an operation is to reify the identity of the people by reducing it to one of its many possible forms of identification.

11. *Ibid* at 164. In this section of her essay, Mouffe is primarily engaged with interpretation of Schmitt's *The Crisis of Parliamentary Democracy* (Cambridge, MA: MIT Press, 1985).

12. Mouffe, "Carl Schmitt," *supra* note 10 at 171-174.

13. *Ibid* at 167-168, 173.

mental health identity as a constitutive feature of “mental health law and policy.”

I. *Autoethnography*¹⁴ (*in a mad, mad, mad, mad world*)

1. “...an expert in the area of mental health law and policy”

My research in the area of mental health law and policy—published and (far more voluminously) unpublished—has been mostly preoccupied with laws and medico-legal practices relating to decision-making capacity. I have focused primarily on capacity to make decisions about medical treatment, and more narrowly still, on the institutional arenas in which this capacity is determined as a criterion of, or alternatively a status supplementary to, involuntary psychiatric hospitalization.

My interest in legal capacity traces back to 2002, when I assembled a doctoral research proposal that contemplated taking a grounded theory approach to interviews I was determined to do with participants in Ontario Consent and Capacity Board (CCB) hearings. I was particularly concerned to speak with persons who had been subject to hearings in which their capacity to make treatment decisions had been in issue: both those who had successfully overturned a psychiatrist’s declaration of incapacity and those who had failed to overturn the declaration. My aim was to bring the perspectives of these individuals on the facts and values of central relevance to the dispute into relationship with the perspectives of professional and familial participants, and then, ultimately, to assess whether or how these various perspectives were reflected in the reasons for decision. I spent about eight months sifting through CCB decisions while seeking allies to assist in my war with the University of Toronto’s research ethics board (REB).

My disagreement with the REB turned on how to obtain consent to participate where a proposed interview subject had been deemed incapable of making decisions about some form of treatment. In successive rounds of correspondence, the REB insisted that my access to such individuals should be contingent on consent from the substitute decision-maker for treatment. This was inconsistent with the governing law in Ontario

14. See Carolyn Ellis, Tony E Adams & Arthur P Bochner, “Autoethnography: An Overview,” online: (2011) 12:1 Forum: Qualitative Social Research 10 at 1 <www.qualitative-research.net> [citations omitted].

Autoethnography is an approach to research and writing that seeks to describe and systematically analyze (graphy) personal experience (auto) in order to understand cultural experience (ethno). This approach challenges canonical ways of doing research and representing others and treats research as a political, socially-just and socially-conscious act. A researcher uses tenets of autobiography and ethnography to do and write autoethnography. Thus, as a method, autoethnography is both process and product.

which strictly circumscribed the authority of those appointed to make treatment decisions. Moreover, it was inconsistent with the fundamental premise of my inquiry— i.e., that the legal arenas for disputing decision-making capacity should be critically appraised in a manner sensitive to the operation of familial and professional power, and with this, the potential for silencing or marginalizing the perspectives of those seeking to vindicate their legal capacity. Finally, it was unworkable for pragmatic reasons, as the mental health bar in Toronto had been very clear that they would advise their clients not to participate in my study should consent of the substitute decision-maker for treatment be required.

In a final round of correspondence, the REB admitted the impropriety of requiring substitute consent from the decision-maker for treatment. Its final position, however, was that my access to persons deemed incapable of certain treatment decisions would be contingent on my obtaining from the treating psychiatrist a positive opinion about the individual's capacity to consent to an interview about the CCB process. Here my response was perhaps more controversial. In answer to the REB's concern that I not serve as the arbiter of capacity to consent to my research, I had earlier proposed that a mental health professional experienced in assessing decision-making capacity accompany me in the interviews, to watch for signs of lack of understanding or appreciation of the goals and risks of research participation, and, where appropriate, to attempt to better convey that information and assess for inability to process it. I acknowledge that this was itself arguably an insulting and dignity-infringing proposal. At the time, I felt it would be possible to bring on an occupational therapist or other who was sensitive to the issues, including the equality principles, at stake. In any case, this was in my view a preferable alternative to the REB's proposal, whereby involvement in my research would be contingent on a capacity determination by a psychiatric professional likely to be centrally involved in the wider dispute about treatment incapacity.

This final standoff marked the end of my idealized research project intended to expose the perspectival construction of decision-making capacity. On reflection, the fundamental problem with my proposal was perhaps something that the REB did not appear, on the surface, to be concerned about. That is, the fundamental problem—for all my tentative efforts to shape the project through consultation with the mental health bar and various experts in research design—was my basic undeservingness of trust. I was seeking entry into a complex and highly contested field with very little understanding of the context and of what was at stake for the major players. My research questions reflected a rough theoretical framework of relational autonomy and the need to align capacity determination with

liberal legalism's deep commitment to value pluralism. But I had no clear conception of how my project linked up with the aspirations of others in this field. My proposal was both naïve and overly reliant on expert (or wanna-be-expert) authority. However, the REB's handling of it still rankles.

My research on questions of capacity and psychiatric treatment since then has drawn not on conversations with living, affected, people, but rather on legal decisions, medico-legal texts, to some extent philosophy of psychiatry and, to an even more limited extent, autobiography. At some point I hitched my wagon to a team investigating the public's (or various subsets of the Canadian public's) knowledge and opinions about the state of the law on substitute consent to research. That project refrained from engagement with persons deemed incapable of research participation; the obstacles to REB approval were so clear that this was not even proposed. More recently, I returned to the questions that brought me to mental health law and policy in a paper addressing tensions between expert knowledge—represented by global mental health policy unfolding at and beyond the World Health Organization (WHO)—and dissenting perspectives advanced by Disabled Persons Organizations during the negotiation and implementation of the *Convention on the Rights of Persons with Disabilities*.¹⁵

However, somewhere along my academic trajectory I lost the central threads that might have linked the start of my journey to where I am now. I refer to the deep ambitions of my proposed doctoral research, its concern to track the phenomenon whereby the testimony of individuals undergoing capacity assessment is translated from reason to symptom. My imagined dissertation ended its life as a tangle of crisscrossing ideas, overlapping textures spanning a decade and more and then disappearing in various directions, all in the effort to produce an insight or two worth retaining on the value-laden and politically volatile category of capacity to make treatment decisions, along with its shadowy companion, "insight." The thesis lies dormant in a collection of crackling and jostling electronic files.

All this takes me squarely into the contested territory sketched in my introduction, and so to the question: who am I, and where do I stand in the arenas of mental health law and policy? My work on capacity and psychiatric treatment strains toward a unified message—namely, that we must work harder to create the structural conditions, the social and institutional and conceptual supports, to assist in disrupting the hegemony

15. 13 December 2006, 2515 UNTS 3 (entered into force on 3 May 2008). See Wildeman, *supra* note 8.

of the individualizing and responsabilizing, punishing, silencing models of “mental health” and “mental illness” that too often are determinative of legal dispositions affecting fundamental rights. But that message is delivered from a nowhere-land, as if written by an invisible hand. Where am *I* situated among the competing perspectives that co-constitute the sites of mental health law and policy, the sites I scrutinize with such interest?

Let me say just a little more about how this question comes up in my daily life. I sit on the volunteer board of the Canadian Mental Health Association, Nova Scotia Division (CMHA-NS). That organization’s origins reach back to the mental hygiene movement, which in Nova Scotia took on such social purification missions as screening new immigrants and schoolchildren for mental health problems for the purposes of exclusion or “special” treatment—“special” homes, “special” classes, “special” education.¹⁶ However, its mandate evolved over time from a protective one to one dedicated, in significant part, to creating spaces for enhanced peer support and what is now termed first voice advocacy.¹⁷ Thus while not a “consumer-” or “survivor-” led organization (terms I take up in some detail in Part II), CMHA-NS has come to identify as (indeed to brand itself as) inclusive of and guided by the perspectives of persons who are experiencing or who have experienced mental health problems. In this, CMHA-NS may be distinguished from, for instance, the family-centred perspectives of the Schizophrenia Society.¹⁸ In constituting the CMHA-NS board, we thus tend to (though we are not formally mandated to) consider the diversity of perspectives represented. I am identified as a legal expert. At this time, just one of our eight directors actively identifies as contributing a first voice perspective. Others are generally understood as allies: helping professionals, financial professionals, business professionals active in promoting mental health in and beyond the workplace. My identification as mental health-affected, or not, has never really come up.

Other arenas of mental health law and policy in Nova Scotia call for more formal self-identification. For instance, the province’s *Involuntary Psychiatric Treatment Act* mandates that review of involuntary hospitalization and treatment be conducted by tripartite panels consisting of a psychiatrist, a lawyer (“who express[es] an interest in mental health

16. Canadian Mental Health Association, “History of CMHA” (CMHA), online: <www.cmha.ca/about-cmha/history-of-cmha>.

17. See Judith Fingard & John Rutherford, *Protect, Befriend, Respect: Nova Scotia’s Mental Health Movement, 1908–2008* (Black Point, NS: Fernwood, 2008).

18. *Ibid.*

issues”) and a layperson.¹⁹ The third category is more fully described in section 65(2)(c) as follows:

[P]ersons who do not meet the criteria of clauses (a) and (b) [i.e., not a psychiatrist or lawyer] and who express an interest in mental health issues and preferably are or have been a consumer of mental health services.²⁰

Thus Nova Scotia inscribes the category of mental health “consumer” into its laws on the oversight of legally-sanctioned psychiatric force. What are the implications of this? So far, I have turned the “who am I?” question on myself. But this is something I cannot answer except in relation to where others in the field of mental health law and policy stand. Who are these representative consumers? What, if anything, defines the coherence of the consumer perspective, the consumer “identity,” or “experience?” What are the characteristics—or perhaps most importantly, the ideological positions or analyses—of those occupying such legally constituted spaces for mental health identity, putatively functioning to legitimate coercion?

As one who is classed as a legal expert—and moreover, one who takes no psychiatric medications, attends no regular meetings with psychiatric professionals, and does not identify (at least, not publicly, or with certainty) as mental health-affected, disordered, or disabled—I would not consider applying for the position carved out by section 65(2)(c) of the *Involuntary Psychiatric Treatment Act*. Of course, the criteria for tribunal membership do not rule out the possibility that persons occupying the role of psychiatrist or lawyer may draw upon insights gained as “a consumer of mental health services,” or otherwise proceeding from personal experiences one is comfortable packaging in the discourse of mental health. Yet the fundamental question remains: what does one bring to the work of judgment, of sorting and prioritizing the facts and values placed in issue before such a tribunal in its mandate of overseeing psychiatric coercion? It is a question of where one stands—a question that, unstated if not stated, affects the credibility and authority of all those who participate in the arenas of mental health law and policy, including those who assume the ostensibly neutral status of experts.

2. Pinned

A few years ago, in a medical consultation framed around my persistent worries about memory loss, my family doctor speculated aloud as to whether the problem might be ADHD. I was taken aback; perhaps a little

19. *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 65(2).

20. *Ibid*, s 65(2)(c).

bemused. If anything, I suggested, I am *too* on-task. I have a tendency to indulge in footnotes that expand to the status of novellas; distractibility is the least of my problems. But what if that tunnel vision, she gently persisted, is itself an expression of ADHD? I was doubtful. Appalled, even. (If I am to get a diagnosis, can't it be something romantic or at least vaguely interesting—something that does not reduce my self-image to that of a squirmy six-year-old boy?) But I was also a little curious. Perhaps a little desperate. At that point, I was in the final throes of the tragic (for me) abandonment of my doctoral dissertation. My doctor got down to brass tacks: “This is how it works. If the pills help you stay on task *and* complete the task, then you have ADHD. If they rev you up [she said something like that; I don't remember exactly what she said—did I mention memory problems?] then you don't have it.”

I respect my doctor. She saw me through two pregnancies and various run-of-the-mill matters involving my health and that of my two boys. But this was something new. Was she messing with my mind? More concerningly, was there something beyond our two-minute conversation, some telltale symptom I had betrayed over the years, without my knowing? Had I—as I so frequently do, in writing and in speech—interrupted my train of thought overmuch, as if overcome by the force of the incoming train? Had I failed to conceal that *thing* I do with my hands, that excited clawing flapping tensing-up thing that no one, not even (indeed especially not) my spouse or kids, should ever see?²¹ Am I doing that thing all the time? I want to do it right now. I wanted to do it as I sat across from my doctor, meeting her gaze. Could she tell?

I walked out and pretty much forgot the whole conversation.

Fast-forward to a few years later; indeed, just a few weeks ago. I was back in her office—my doctor's—worrying about my bad memory. I had finally summoned the courage to consult a neurologist (the first time I was put on a months-long referral list and then backed out just before the appointment). He and I had had a brief but oddly satisfying chat. He did not appear to be familiar with my file. He was not much interested in my family history. It appeared that my “high functioning” as a law professor, in addition to a few taps on the knee and follow-the-finger trials, was sufficient to disclaim my memory-related anxieties. These anxieties and the problems fueling them were symptomatic, he said—to his young, obviously extremely bored, resident—of my overtaxed familial

21. One time my mother caught me doing the *thing* down in the laundry room, when I was about 12. I will never forget the utter shame of it. Only she can make fun of the thing—she does a wicked impression.

and professional life. Perhaps my situation shaded into one or another diagnostic category (bipolar? I suggested); likely not bipolar, more likely ADHD—most probably ADHD, he said, making a few stabs in his notebook—but this was not a neurological problem and not something I should worry about.

So there I was, back with my family doctor for the obligatory post-referral consult. A complete waste of time and tax dollars. I archly informed her of my diagnosis: modern life! She turned the discussion rather deftly to ADHD.

This time, she had backup. She handed me the Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist.²² The cover sheet states that the checklist was designed to be consistent with DSM-IV, and was “developed in conjunction with the World Health Organization (WHO) and the Workgroup on Adult ADHD.” The cover also provides a concise rationale for use of the checklist:

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it. Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.²³

The checklist comprised 18 brief questions, on one side of a page. The first was ominous: “*How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?*”²⁴ I suppose that depends on your definition of “challenging” and “final details,” I thought. I recalled my disastrous dissertation; also my ancient draft of “Paradise Law,” a pulsating tome on John Milton and the Ancient Constitution that I meant to dig up and sort out and mail out years ago. And the like: buried, blasted things. I checked: “Often.” I wondered, what happens if I fail to finish the checklist?

“*How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?*”²⁵ Aha. I began to worry that the checklist would ask about the *thing*.

22. World Health Organization & Workgroup on Adult ADHD, “Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist, online: National Resource Center on AD/HD <www.help4adhd.org/documents/adultadhdselfreportscale-asrs-v1-1.pdf>.

23. *Ibid*.

24. *Ibid* [emphasis added].

25. *Ibid* [emphasis added].

It took less than a minute to complete. I passed it over and about 3 seconds later the diagnosis was in. Typically, my doctor added, adults are diagnosed when their children are diagnosed. “There is a strong genetic component,” she said. It was quite likely that one or both boys had it.

That was the only point in the exchange at which I felt angry, in that sudden way one gets angry when one’s children are wronged.

Again, I left without a prescription. But this time I found the conversation harder to forget.

* * *

Mine is not an unusual story. Many of us are familiar with the staggering rise in ADHD diagnoses in children over the past few decades in the U.S. and Canada. A study recently published in the *Journal of the American Academy of Child & Adolescent Psychiatry*, drawing on data from the National Survey of Children’s Health for the period 2003–2011, found a 42 per cent increase in parent-reported diagnoses of the disorder over that period.²⁶ In 2011–2012, 11 per cent of children aged 4–17 were reported by their parents as having been diagnosed with ADHD.²⁷ The same study found that the proportion of ADHD-diagnosed children receiving ADHD medication had also increased, by as much as 28 per cent since 2007–2008.²⁸ These findings are supported by other prevalence studies over the past decade.²⁹

The adults, it turns out, are lagging behind—but efforts are being made to help us catch up. According to a study published in 2011 reporting on a retrospective analysis of 342,284 insured, employed individuals in the U.S. and their families, diagnoses of adult ADHD rose more than threefold between 2002 and 2007 (1.23 to 4.02 cases per 1000 insured members).³⁰ The study authors suggest that the results “may underestimate the true prevalence of diagnosed ADHD in the [U.S.] population,” given the restriction of the data set to employed persons and their dependents.³¹

26. Susanna N Visser et al, “Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated Attention-Deficit/Hyperactivity Disorder: United States, 2003–2011” (2014) 53:1 *J American Academy Child & Adolescent Psychiatry* 34 at 39.

27. *Ibid* at 38. See also Alan Schwarz & Sarah Cohen, “ADHD. Seen in 11% of US Children as Diagnoses Rise” *New York Times* (31 March 2013), online: <www.nytimes.com/2013/04/01/health/more-diagnoses-of-hyperactivity-causing-concern.html>.

28. Visser et al, *supra* note 26 at 41.

29. Mark L Wolraich et al, “The Prevalence of ADHD: Its Diagnosis and Treatment in Four School Districts across Two States” (2014) 18:7 *J Attention Disorders* 563; Kathleen Ries Merikangas et al, “Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A)” (2010) 49:10 *J American Academy Child & Adolescent Psychiatry* 980.

30. Leslie Montejano et al, “Adult ADHD: Prevalence of Diagnosis in a US Population with Employer Health Insurance” (2011) 27:S2 *Current Medical Research & Opinion* 5 at 5.

31. *Ibid* at 8-9.

Another study (based in “national surveys of ambulatory care visits to physicians’ offices and outpatient and emergency departments of general and short-stay hospitals”)³² reports a threefold increase over the period 1996–2003. Prescription rates are also rising dramatically, with reports of growth in the adult market outstripping the increase in childhood prescriptions (one study reports an annual growth rate of 17 per cent for men and 21.4 per cent for women aged 20–44 from 2000–2005).³³

The trend toward increased prevalence of adult ADHD is likely to accelerate in coming years. This is due in part to the fact that DSM-5, which came out in 2013, has relaxed the diagnostic criteria for adults³⁴ while adding illustrative examples involving both teens and adults. This is combined with an intensification of pharmaceutical industry marketing of ADHD treatments directed at the adult market.

Allen Frances, who was chair of the Task Force that produced DSM-IV (released in 1994), has been one of the most high-profile critics of DSM-5, both the processes through which changes were made and the substance of many of those changes. In a 2010 article in the *Los Angeles Times*, he referred to DSM-5 as threatening to “extend the reach of psychiatry dramatically deeper into the ever-shrinking domain of the normal.”³⁵

Following the release of DSM-5, Frances summed up his position on his blog *DSM5 in Distress* as follows: “My best advice to clinicians, to the press, and to the general public—be skeptical and don’t follow DSM 5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication.”³⁶ He outlined ten of what he deems the most egregious changes adopted by DSM-5 (“the ten changes that make no sense”), advising clinicians, the press, and the general public to “[j]ust ignore”

32. Richard H Weisler & David W Goodman, “Assessment and Diagnosis of Adult ADHD: Clinical Challenges and Opportunities for Improving Patient Care” (2008) 15:11 *Primary Psychiatry* 53 at 54, citing Jayashri Sankaranarayanan, Susan E Puumala & Christopher J Kratochvil, “Diagnosis and Treatment of Adult Attention-Deficit/Hyperactivity Disorder at US Ambulatory Care Visits from 1996 to 2003” (2006) 22:8 *Current Medical Research & Opinion* 1475.

33. Lon Castle et al, “Trends in Medication Treatment for ADHD” (2007) 10:4 *J Attention Disorders* 335. See also Weisler & Goodman, *supra* note 32.

34. See, e.g., National Resource Center on AD/HD (a program of Children and Adults with Attention-Deficit/Hyperactivity Disorder), “ADHD and the DSM 5,” online: <www.help4adhd.org/documents/adhd%20and%20the%20dsm%205%20fact%20sheet%202.0.pdf>.

35. Allen Frances, “It’s Not Too Late to Save ‘Normal’: Psychiatry’s Latest DSM Goes Too Far in Creating New Mental Disorders,” *Los Angeles Times* (1 March 2010), online: <articles.latimes.com/2010/mar/01/opinion/la-oe-frances1-2010mar01>.

36. Allen J Frances, “DSM 5 Is Guide not Bible—Ignore Its Ten Worst Changes: APA Approval of DSM-5 is a Sad Day for Psychiatry” (2 December 2012), *DSM5 in Distress* (blog), online: <www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes>.

them.³⁷ His top ten are all either new diagnoses or expanded criteria for assigning old diagnoses.

Frances's naughty list includes:

- Adult Attention Deficit Disorder (a subtype of Adult ADHD);
- Binge Eating Disorder (“[e]xcessive eating 12 times in 3 months,” which after DSM-5 is “no longer just a manifestation of gluttony and the easy availability of really great tasting food”);
- Minor Neurocognitive Disorder (“the everyday forgetting characteristic of old age,” which, translated to a DSM diagnosis, is likely to create “a huge false positive population of people who are not at special risk for dementia”);
- Major Depressive Disorder (revised to encompass what Frances calls “[n]ormal grief...thus medicalizing and trivializing our expectable and necessary emotional reactions to the loss of a loved one and substituting pills and superficial medical rituals for the deep consolations of family, friends, religion, and the resiliency that comes with time and the acceptance of the limitations of life”); and,
- Disruptive Mood Dysregulation Disorder (a new diagnosis aimed at “vulnerable children,” effectively “turn[ing] temper tantrums into a mental disorder”).³⁸

Frances is particularly scathing on the last-mentioned development, which he briefly puts into context:

During the past two decades, child psychiatry has already provoked three fads—a tripling of Attention Deficit Disorder, a more than twenty-times increase in Autistic Disorder, and a forty-times increase in childhood Bipolar Disorder. The field should have felt chastened by this sorry track record and should engage itself now in the crucial task of educating practitioners and the public about the difficulty of accurately diagnosing children and the risks of over-medicating them.³⁹

Much of Frances's critique is directed at the conflict of interest that inheres in the arrangement whereby psychiatrists (through the American Psychiatric Association, which publishes and oversees the evolution of DSM) are responsible for delineating the borders of their professional

37. *Ibid.*

38. *Ibid.*

39. *Ibid.*

turf.⁴⁰ As to his own role as lead on DSM-IV—under the sway of which the cited increases in diagnosis of ADHD, Autism Spectrum Disorder, and childhood Bipolar Disorder occurred—it is possible that Frances is in denial. In his recent book, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, he lays the blame for overdiagnosis and overmedication on rushed or undereducated practitioners, profit-hungry pharmaceutical companies, and consumer susceptibility to hype and to the promise of a quick fix.⁴¹ He stands by the diagnostic categories of DSM-IV and the utility of these categories in alleviating individual suffering. In short, Frances's mission is not to crack the epistemological foundations of DSM, but to get back to basics: to distinguish the "true" illnesses from the fads. Of course, that is the mission of all who have been at the helm of DSM, and the controversy and friction among these designers of normal may be considered part of the ongoing story of historical ontology.

It is a common criticism of the steep increases in diagnosis of and prescriptions for childhood ADHD that parents and schools are failing to address the root social and institutional causes of the behaviours labeled aberrant or maladaptive in children. Broad systemic reforms—including reforms aimed at making schools more conducive to the flourishing of all students⁴²—have been argued to constitute a more promising line of inquiry and experimentation than the risky social experiment of marking out one in ten kids (and rising) for medicalized (self) control.

But what of the adults? What, if any, societal reforms—at home, at work, in our expectations of ourselves and others—might stave off the onset/onslaught of Adult ADHD and the whole motley crew of other malleable disorders, from the most faddish to the stickier kinds, the kinds that fit so well you would think we were made for them?

* * *

40. *Ibid* (arguing that the psychiatrist members of the Task Force stand in "an intellectual, not financial, conflict of interest that results from the natural tendency of highly specialized experts to over value their pet ideas, to want to expand their own areas of research interest, and to be oblivious to the distortions that occur in translating DSM 5 to real life clinical practice (particularly in primary care where 80% of psychiatric drugs are prescribed)"). On the exposure of a significant undisclosed financial conflict of interest on the part of the Chair of the DSM-5 Task Force, see Allen Frances, "Holding Psychiatry to a Much Higher Ethical Standard" (22 Jan 2014) *The Blog: Huffington Post Science* (blog), online: <www.huffingtonpost.com/allen-frances/holding-psychiatry-to-a-m_b_4641102.html>.

41. Allen Frances, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (New York: HarperCollins, 2013).

42. See AD Pellegrini & Michael Horvat, "A Developmental Contextualist Critique of Attention Deficit Hyperactivity Disorder" (1995) 24:1 *Educational Researcher* 13.

Back to my “diagnosis”: my sham, junk diagnosis. I would like to say it means nothing to me. And yet... I am just a little ADHD-curious. What would it feel like to be on those mysterious attention-sorting stimulants? Who might I become? What if—and here is the tenderest thought, the one I contemplate with a short sharp pang (perceived deficit)—what if I could teach better, could give perfectly timed and funny and impeccably reasoned lectures; what if—circling ever closer to what I value most among those matters most suffering attention deficit in the junk drawers of my life—what if I were to finish the various papers abandoned in various states of growth or amputation, perhaps even the dissertation ...polish it up, produce a book? And still be home at a reasonable hour to make wholesome dinners and play board games with my grateful and well-cared-for children and spouse. Enjoying an endless parade of evenings and weekends, free of work and yet anchored in meaningful work. Just what value—apart from their street value—might those pills hold for me?

I am hovering between yes and no (I am quite sure the answer is no). And while I hover, while I wobble, I ask myself: what does it mean to undertake the critical ontology of ourselves, in the thick of biopower? I consider the personal and social significance of psychiatric diagnosis, and the various strands of identity-based claims made in relation to such diagnoses. What, I ask, would be the implications of my claiming an identity constituted in part through mental health/psychiatric disability—the implications for my work, my family (my boys with their newly-minted “ADHD genes”), my relationships with others who adopt one or another form of disability-based identity in the arenas of mental health law and policy? Not that anyone outside my immediate circle should care about my individual passage through the tiny portal of ADHD. But what about the rush of thousands upon thousands through that same portal, or adjacent ones? What does *that* mean for the politics of mental health identity, and for mental health law and policy?

It would be ridiculous to believe that a one-minute self-test based in questions about foot-wagging might wholly reconstitute my professional and political identity. And yet the categories of mental health/psychiatric disability are working on (and in) me, on and in all of us. They worked me right into that consult, and worked me over. How else are these forces working? And how should we respond? What relationship, if any, does my experience of being outed as a squirmy six-year-old boy have to the relationships of domination and subordination played out every day, every minute of every day, in the arenas of mental health law and policy, along a continuum that extends from the rawest physical violence to more subtle colonization? I may stand in solidarity with those who place their survivor

identity, or Mad identity, at the heart of their mental health politics—but my experience is no ticket to a radicalized or otherwise politically recognizable identity. It is more of an irritation, an irritating invitation to reflect further on my and others' constitution through the categories of order/disorder expressed through psychiatry and in the arenas of mental health law and policy.

3. *Phantasms (the spectral / between worlds)*

My sense of solidarity with those who have had identification under the sign of psychiatric disability forced upon them is, in a word, spectral. It is neither here nor there. This parallels the spectral solidarity I feel with my birth mother, from whom I received two brief letters over two decades ago (I never met her, although she visited my city and circled my block a few weeks before she died): a woman who, I am told, wrestled bravely with her demons and with her zealous father; who cut herself when she was young—she was a cutter; who bore me in secret at age 17, and, less than a year later, started a vaguely mystical women's collective at Harvard; a woman who “struggled with bipolar disorder all her life.” If I am going to inherit a disorder, let it be hers—give me a bold cup of that woman's mania-inclined bipolarity over ADHD (*fucking* ADHD) any day. Perhaps it might open up a direct line between us, a humming, crackling current, a means of listening in as “the ghost of electricity howls in the bones of her[/my] face.”⁴³

That is to say it is as if my present position in relation to mental health identity hovers spectre-like between worlds. This I experience less through the language of psychiatry than through a symbolic language reflecting the deep reach of dualistic psy-logics into my own defining assumptions and relationships—reflecting, also, a will to get beyond those disciplinary logics. On the one side of this symbolic divide is my unconditionally loving, savvy, brick-solid sane social mother to whom I owe everything; on the other is my absent, Mad mother. On the one side is my mild-mannered, academically overachieving childhood self; on the other is my ridiculously charismatic (like me, adopted) brother, one of the pioneering Canadian children given Ritalin back in the early 1970s for what was termed hyperactivity. On the one side is, again, me (now just a little bit edgier, exploring my newly-sprung adult life); on the other is my much edgier first boyfriend, who after a few years spiraled into a psychosis so-called (the terms kept changing) and started acting in ways

43. Bob Dylan, “Visions of Johanna,” *Blonde on Blonde* (Columbia Records, 1966).

that so scared and angered me I eventually had just enough reasons (these were not the only reasons) to leave my home province for good.

And then the two sides begin to blur—fast forward a little and I am a few years older, still young, now struggling to express and to contain a flying-apart of self I have learned to manage through a fixation on the limits of my body, my borders—eating, vomiting, repetitively and ritualistically as if working out a thesis about self-alienation and reconciliation, self-present plenitude and present absence, sacred and profane. This was a time of my life I experienced as a kind of sacrament: a time out of time. It is not a time or a part of my “identity” that I connect to my work in mental health law and policy. That story and the others resist coding in singular or monological terms—on one side or the other of the poles of identity and difference, order and disorder, normal and mad. I do not feel at home in a world that forces a choice of sides. If I have a choice about the constitution of my identity then I choose to hold on to all its unruly dimensions, to reject a master code for their sorting and preferencing. The spectral identity floats beyond the poles, not leaving them behind but reflecting on their provisionality.

II. *Toward a political taxonomy of psychiatric subjectification*

This has been the first part of a two-part essay exploring identity in mental health law and policy. In it, I have suggested two variations on the concern that mental health identity is getting in the way of social justice. First is the worry that the increasingly intensive emphasis on mental health in social and political discourse (as mental illness comes “out of the shadows at last”)⁴⁴ may, despite the rootedness of this development in a will to redress real and often overlooked forms of suffering, paradoxically promote a corrosive individualizing ethic whereby failure to thrive is reduced to personal dysfunction, and the deeper social-structural dimensions of injustice are pressed further back into the shadows. The second, attendant worry is that mental health identification, deployed as revaluated currency in the market of social justice claims-making, may function to perpetuate the deep binary logic of norm and deviation, whereby madness and its correlates are reflexively linked with incapacity and dangerousness and so set off for heightened surveillance, intervention and containment.

44. Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (May 2006) (Chair: The Honourable Michael J.L. Kirby). And see Kimberley White, “Out of the Shadows and into the Spotlight: The Politics of (In)visibility and the Implementation of the Mental Health Commission of Canada” in Kimberley White, ed., *Configuring Madness: Representation, Context and Meaning* (Oxford, UK: Inter-Disciplinary Press, 2009) 225.

In Part II of this essay, I reflect in more detail on the categories of mental health identification shaping the politics of mental health. I ask how identity or identification—whether as mental health resistor or consumer or liminal/critical interlocutor—sets the horizon of possibility for this politics. I attend in particular to voices from the arenas of radicalized mental health politics/Mad Studies, for insights on avoiding the pitfalls of identity politics while strengthening solidarity and social justice critique within and beyond this diversely-constituted social movement. These insights are, I suggest, illustrative of agonistic pluralism, or of the work of agonizing (mental health) identity as a necessary component of the critical ontology of ourselves, and moreover, of political and legal legitimacy. I note in particular the call, within these emerging models of social movement building, for a co-engagement of academic and experiential expertise on the way to new critical-deliberative conversations. Part II thus ends by opening the project of critical ontology onto the coordinate project of a critical-deliberative politics of agonizing identity in and beyond mental health law and policy.

