MENTAL ILLNESS, ADDICTION, STIGMA AND HETEROSEXUAL GENDER NORMS

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by

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Abstract

The stigmatization of individuals diagnosed with a mental illness and/or addiction and who are labelled as mentally ill and/or addicts has long been seen as a barrier to treatment and recovery. Anti-stigma campaigns in Canada date back to the 1950s, and yet, recent data demonstrates that stigmatizing behaviours and attitudes in the Canadian public towards individuals diagnosed with a mental illness and/or addiction and labelled as mentally ill and/or as addicts remains pervasive. Yet public health resources continue to be spent on anti-stigma initiatives that use the same normalization approaches that have yet to be shown to have long-lasting impacts on the stigmatizing behaviours and attitudes exhibited by the Canadian public. In this thesis, I argue that there are very strong associations between the stigma against individuals who are diagnosed with a mental illness and/or addiction and the constituting, policing and restraining of heterosexual gender norms. I investigate: firstly how the stigmatization of individuals who are diagnosed with a mental illness and/or addiction is constituted by the loss of power that occurs with the denial of the diversity and fluidity of gender and the subsequent policing of rigid dualistic gender categories and constructs; secondly I look at how this type of stigma in turn doubles the effects of this powerlessness, and doubles the aggression towards individuals diagnosed with a mental illness and/or addiction; and finally, I consider how this might inform strategies to combat the stigma associated with mental illness and addiction, and what some alternatives to combating such stigma might be, with the hopes of meaningful recovery.

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I would like to dedicate this work to my Uncle David and a dear friend, who both left this earth far too soon. I hope this work opens up a much-needed discussion.

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Chapter 1 Introduction

1.1 Introduction and Overview

Stigma and Mental Illness

Living with depression for nearly 20 years, I've learned that at times, it is not, in fact, the incapacitating sadness that proves to be the most difficult to contend with, but rather the disclosure to others of the silent struggle. I have always found that it is far easier to conceal the fact that I have been previously diagnosed with depression, and the fact that I have taken medications and attended counseling sessions in the hopes of remedying the melancholy that has existed in my soul, than to open myself up to the sometimes very harsh judgment and criticism espoused by others.

Interestingly, I have discovered, over time, that there is a short moment that exists right before one is about to disclose that almost brings about a sense of elation, a rush that echoes and reverberates within the body — a sliver of time that seems to be filled with possibility. And it is not because there will be any sort of relief after the disclosure — on the contrary, it is in that moment, right before disclosing one's history of mental illness to another, that one can, however briefly in the mind, not own such an identity. One is, for all intents and purposes, free from a label that at many times has been associated with 'instability,' 'being overly emotional,' 'fragility,' 'laziness,' 'unreliability,' 'bad worker,' and 'volatility.'

And I know that these fears of disclosing a history of mental illness are not ill-founded — the stigma experienced by those living with mental illness and addictions in

Canada has drawn an increasing amount of attention in recent years. The Canadian Medical Association's 2008 report card on health care in Canada demonstrated the pervasiveness of such stigma — it was found that only half of Canadians would tell a friend that a family member has a mental illness and 46 per cent of Canadians think the term "mental illness" is used as an excuse for bad behaviour (Sullivan, 2008).

And so under the fog of these alarming new statistics regarding Canadians' negative attitudes and behaviours toward individuals diagnosed with a mental illness and/or addiction, the newly-formed Mental Health Commission of Canada unveiled one of their key initiatives — the implementation of a national anti-stigma campaign. The campaign, titled *Opening Minds*, has been lauded as the first national effort to reduce stigma against those diagnosed/labelled as having a mental illness.

But it is not the first time significant anti-stigma work has been done in Canada — as Heather Stuart writes in *Fighting Stigma and Discrimination is Fighting for Mental Health* (2005), Canadians have had a long and internationally-renowned tradition of anti-stigma work. One of the first anti-stigma campaigns to take place in Canada dates back to the early 1950s — when radio programs, discussion groups, educational materials and films were used in a small Saskatchewan town (Cumming & Cumming, 1955, 1957) in order to improve the community's attitudes toward individuals diagnosed with a mental illness and labelled as mentally ill, "both in terms of residents' ability to interact with people who were mentally ill, and their sense of responsibility towards broader social issues surrounding mental health and mental illness" (Stuart, 2005, p.S23). This study revealed something that has been demonstrated time and time again throughout the

history of anti-stigma campaigns in Canada — changing negative attitudes and behaviours towards individuals diagnosed with a mental illness and labelled as mentally ill is much more difficult than one might think. The campaign in the small Saskatchewan town was unsuccessful, and in fact, the community's reactions changed from interest, to anxiety, to outright hostility — 23 years after the first research study was conducted, some new researchers revisited the small town, and conducted the same survey, only to find that the exact same negative attitudes and behaviours were ever-present (Everett, 2006; Stuart, 2005).

Nearly a dozen high-profile anti-stigma campaigns have been launched across Canada since the 1950s by a variety of reputable mental health organizations including the Centre for Addiction and Mental Health, the Canadian Mental Health Association, and the Canadian Psychiatric Research Foundation. An example of one of these anti-stigma campaigns is the Canadian Psychiatric Research Foundation's 2004 national campaign titled "Imagine…2004," which included a series of public service announcements and newspaper advertisements — this national campaign showed little long-term success in changing people's stigmatizing attitudes and behaviours towards individuals diagnosed with a mental illness and labelled as mentally ill as demonstrated by the never-changing stigmatizing attitudes demonstrated in the Canadian Medical Association's 2008 report card on health care in Canada.

But despite evidence that anti-stigma campaigns in Canada should avoid reinventing the wheel (i.e. using the biomedical model to define mental illness, the normalization approach in their anti-stigma messaging, and relying on media and peer-to-

peer based contact to reach broad audiences) and choose to develop alternative evidence-based strategies to combat the stigma associated with mental illness and addictions, the Mental Health Commission of Canada moved forward using this very model and approach. The Commission launched their anti-stigma initiative, *Opening Minds*, on October 2nd, 2009. This initiative, announced Howard Chodos, then chief of staff of the Mental Health Commission of Canada, at a *Women, Gender and Mental Health Conference* which I attended, would be modeled after similar anti-stigma campaigns in England (*Beyond Blue*), Australia (*Changing Minds*) and New Zealand (*Like Minds, Like Mine*). Each of these campaigns used the biomedical model of defining mental illness (i.e. messaging includes the idea that "mental illness is just like diabetes, heart disease, etc. and requires medication"). Each of them also used a normalization approach in their campaigns (i.e. messaging includes "people with mental illness are just like you and me") and used media and peer-to-peer based contact to reach broad audiences (e.g. public service announcements with individuals who have been diagnosed with a mental illness explaining how they are "just like everyone else") (Chodos, 2007). All of these campaigns (i.e. England, New Zealand and Australia) have yet to demonstrate evidence of long-term impact on citizens' stigmatizing attitudes and behaviours towards individuals diagnosed with a mental illness and labelled as mentally ill. But as discussed above, similar national anti-stigma campaigns launched here in Canada over the past years have not demonstrated meaningful changes in Canadians' stigmatizing behaviours and attitudes towards those diagnosed with a mental illness or labelled as mentally ill either.

The Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative has the two-pronged goal of: 1) encouraging individuals experiencing mental health difficulties to seek help; and 2) helping to eliminate stigma against such individuals. Similar to previous anti-stigma campaigns in Canada, the *Opening Minds* initiative is using a "contact-based education" approach. And though previous campaigns have demonstrated that this approach is not effective, with great hope and exuberance, the honourable Michael Kirby, Chair of the Mental Health Commission of Canada, launched *Opening Minds*. In his keynote speech on October 2nd, 2009 he said,

> *It's time for individuals with mental health problems to live free of stigma and discrimination.*
>
> *It's time for them to move out of the shadows forever and into the light of equal opportunity in Canadian society.*
>
> *It's time for us to remove the labels they're branded with — (Michael Kirby rips off the red stigma signs over French and English Signs) — just like this.*
>
> *(Kirby, 2009)*

But why has the fight against stigma associated with mental illness and addiction proven to be so difficult? At the release of the Canadian Medical Association's (CMA) 2008 report card on health care in Canada, the President of the CMA, Dr. Brian Day, said, "In some ways, mental illness is the final frontier of socially-acceptable discrimination." (CMA, August 8, 2009). One reason might be that although stigma is a familiar concept in the field of mental health, it is still rather complex, and oftentimes over-simplified. The term is often used as a catch-all for a myriad of negative beliefs, attitudes and actions towards individuals diagnosed with a mental illness and labelled as mentally ill. What is often left out of the discussion is that stigma exists within a social power structure that

facilitates it. As Bruce Link and Jo Phelan write in *Conceptualizing Stigma*, stigmatization is contingent on "access to social, economic, and political power that allows…the full execution of disapproval, rejection, exclusion, and discrimination" (2001, p.363). Researchers have found that, in addition to labelling and stereotyping, active discrimination and the misuse of power are the most damaging aspects of stigma.

Of Note on Mental Illness and Addiction

Research has demonstrated that 30 per cent of individuals who are diagnosed with a mental illness will also struggle with an addiction issue throughout their lifetime, while 37 per cent of people who abuse alcohol and 53 per cent of individuals who abuse drugs will be diagnosed with a mental illness during their lifetime (Skinner, O'Grady, Bartha, Parker, 2004). Though research has demonstrated that individuals who are diagnosed with a mental illness are vulnerable to developing addictions problems and vice versa, it is important to note that mental illness and addiction are two separate and distinct categories, with their own unique set of characteristics, history, culture and service delivery structures. Addiction involves the heavy use of psychotropic (or mood altering substances) such as medications and alcohol to the point which it interferes with family, social and work life. It involves physiological dependence (meaning bodily cravings with withdrawal symptoms if these cravings are not satisfied) as well as psychological dependence (i.e. the use of these substances is required to manage moods or is believed to be necessary to function in day-to-day life) (Interim Report of the Standing Committee on Social Affairs, Science and Technology, 2004). In recent years,

research has also demonstrated a prevalence in addictions to gambling and the Internet (though when referring to addictions in this thesis I will be referring to substance dependency). People diagnosed with both mental illness and addiction issues (often referred to as "dual diagnosis") often find themselves going back and forth between mental health and addiction services with neither prepared to address both problems at the same time. Best practice literature notes that mental health and addiction services screen clients for the presence of both to ensure that proper diagnosis and treatment prevail (Rush, 2002).

Women and Men Experience Stigma Differently

Research suggests that women who are diagnosed with a mental illness and/or addiction and labelled as mentally ill and/or as addicts experience the associated stigma differently than men who are diagnosed and labelled accordingly. With regard to addiction, research shows that women who have been diagnosed with an addiction and labelled as addicts experience more stigma than men who have been similarly diagnosed and labelled (World Health Organization, 2009). The example of substance use among pregnant women and mothers offers an illustration. Public discourses and policies surrounding pregnant women who use licit and illicit drugs are oftentimes judgmental, blaming, and unsympathetic (Greaves et al., 2002; Aston, 2009; World Health Organization, 2009). Analysis done by the British Columbia Centre of Excellence for Women's Health (2009) of media discourses and policy responses to these women revealed highly negative attitudes that reflect the perception that these women

deliberately create their own difficult predicaments. Little responsibility was assigned to the system. Yet, in the same study, researchers found that women diagnosed with a mental illness and labelled as mentally ill who were pregnant or mothering were portrayed as not responsible for their situation because their behaviour was regarded as out of their control, and the system was failing them.

These differences in assigning responsibility are linked to the nature of stigma attached to pregnant women's behaviours. Though there has been some shift in Canadian public policy towards embracing harm reduction approaches to substance use and addictions, the unique needs of pregnant women and mothers with addictions issues are frequently neglected. Similarly, negative public attitudes and child welfare policies may harmfully affect women who are pregnant or mothering and who are diagnosed with a mental illness and labelled as mentally ill (portraying these women as unstable mothers whose children should be taken away). These conditions may determine whether or not a woman will report substance-use patterns and/or mental health problems during pregnancy and while mothering.

Stigma associated with pregnant and mothering women with substance-use problems is directly related to heterosexual gender norms. Research has shown that the stigma for women who use licit or illicit drugs is more severe than for men because of women's perceived "place" in society, as those who bear and rear children and who are seen to uphold the moral and spiritual values of society (Ridlon, 1988, p. 25). There is also the negative stereotype that women with addictions issues are sexually promiscuous because of their drug or alcohol use (Copeland, 1997). This association is not seen in

attitudes towards men (Centre for Addictions and Mental Health, 1999). The World Health Organization has found that men are far more likely than women to disclose problems with drug and alcohol use to their health care provider (2009).

With regard to mental illness, the opposite is found. Research demonstrates that men who have been diagnosed with a mental illness and labelled as mentally ill experience more stigma than women. Growing up, boys encounter what William Pollack termed the "Boy Code" — a set of expectations about how boys and men should think, feel and act — these expectations include "be tough," "don't cry," "go it alone," and "don't show any emotion except for anger" (Pollack, 2001, p. 21). These characteristics of traditional masculinity and the stigma attached to any male who does not demonstrate these characteristics can cause men to perceive mental health problems as weakness and thus not seek the necessary help. A comment from a young male blogger who identifies himself as 'untreatable' examines these very ideas on an open blog project titled, *Eliminate the Stigma of Mental Illness*:

> *As a young boy you are taught that men are tough, strong and keep their emotions to themselves or else others will see them as weak. This message is taught by the parents, media and then society reinforces it. So when a man is hit by a turmoil of emotions instead of turning for help he tries to deal with it on his own and depending on the severity of the depression[,] may very well decide his future. Instead of going to his doctor[,] he begins to drink or use drugs to nullify the emotions that he is fighting to get buried which may eventually turn into an addiction but in a way that is okay as society sees men who abuse substances in a lot nicer light then those with mental issues even though the two go hand in hand in a very high percentage. Now this man [may] be a functioning addict but what happens when his issues continue to build to the point*

> *where he loses his job, his family, his home and finds himself on the street panning for loose change. What happens when this man is tired of starving and freezing so decides to grab a gun to rob a bank or a little old lady. Now he is sitting in a jail cell with no alternate substance to cover his demons so the depression is very apparent ands [sic] looks unbeatable. The man has lost his family, friends, material possessions and suicide is a very attractive option when you have nothing left and you want the pain to end. Another jailhouse suicide. Who is at fault? The mental illness definitely holds some responsibility but what about the stigma that led to the decision to follow the wrong path? What would the story be if the man felt comfortable and did not worry whether or not society was going to look down at him so he sought treatment right away[?} Chances are his story would continue to be written instead of a premature end.*
>
> *(untreatable, 2008)*

The comment by untreatable rings true in many ways. Men are much more at risk of committing suicide than women. Research done by Manitoba Health showed that in Manitoba between 1992 and 1999, men committed suicide at more than three times the rate of women even though men's suicide rates had decreased on average by 2.2 per cent while women's suicide rates had increased on average by 12.8 per cent (2004). The greatest number of suicides in the period in which the research took place occurred among men aged 25 to 34; but the risk of suicide was greatest among elderly men over 74 years of age and young men aged 20 to 24 (Manitoba Health, 2004). According to the research, the highest rate of First Nations deaths due to suicide between 1992 and 1999 occurred among young men 25 to 34 years of age (2004). Their rate of death due to suicide was around five times that of all First Nations Manitobans and over 5.5 times that of the non First Nation males in the same age group (Manitoba Health, 2004). Suicide was the leading cause of injury death for First Nations and non First Nations men alike,

but First Nations men were around 1.7 times more likely to die due to suicide than were non First Nations men (Manitoba Health, 2004).

Research also confirms untreatable's comments about the stigma that men encounter with regard to mental illness and the subsequent unwillingness to access treatment options, as it has been demonstrated that men are much less willing than women to access appropriate professional help when experiencing distress (Oliver, 2005).

Research shows that gender stereotypes continue to reinforce social stigma and affect help-seeking behaviour. The World Health Organization writes, "Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men, appear to reinforce social stigma and constrain help seeking along stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorder" (2009).

Women and Men Differ in Their Stigmatizing Attitudes Towards Mental Illness

Research also suggests that there are differences in the way that stigma is applied by men and women. A 2007 Canadian study by Wang, Fick, Adair and Lai titled, "Gender specific correlates of stigma toward depression in a Canadian general population sample," found that factors associated with stigma appear to vary by gender. This research, which examined Canadians' attitudes towards depression, found that men held more stigmatizing attitudes towards mental illness than women. Women health professionals, who had family or close friends living with depression, who believed taking medication may be the best help for depression, and who believed that traumatic

events are a causal factor for depression, held far fewer stigmatizing attitudes (Wang, Fick, Adair & Lai, 2007). These associations were not found in men. In fact, men who identified themselves as health professionals, and who had family or close friends living with depression, strongly associated weakness of character as the causal factor for depression (Wang, Fick, Adair, & Lang 2007). The researchers concluded that gender differences must be considered in initiatives aimed at reducing stigma.

This finding is particularly relevant to the Mental Health Commission of Canada's plan to target health care providers in its anti-stigma initiative. It tells us that, to be effective, messaging targeted towards health professionals needs to take into consideration these demonstrated gender differences in stigmatizing attitudes. One of the target audiences of the Mental Health Commission of Canada's anti-stigma initiative is youth. When looking at the research, it becomes apparent that messaging to youth must take into account that girls' and boys' mental health attitudes and willingness to use mental health services are different in important ways.

Research has demonstrated that gender differences in mental health attitudes and willingness to use mental health services are present early in adolescence. In a study on gender differences in teen willingness to use mental health services it was found that more girls than boys turned to a friend for help for an emotional concern, whereas more boys than girls turned to a family member first (Chandra & Minkovitz, 2003). Similarly, studies have shown that relationships with friends play a crucial role in whether teenage girls think about suicide but have little impact on suicidal thoughts among boys (Bearman & Moody, 2004). Research also found that boys had less mental health knowledge and

experience and higher mental health stigma than girls (Pollack & Shuster, 2001). Research suggests that girls are twice as likely as boys to report a willingness to use mental health services. Parental disapproval and perceived stigma helped to explain the relationship between gender and willingness to use mental health services (Chandra & Minkovitz, 2003).

Research has demonstrated that stigma does not take place in a vacuum and that gender, race, class, sexual orientation, location, ability, and age, must be considered. Studies confirm that anti-stigma initiatives must use an equity-based analysis. A 2003 study by Corrigan, Thompson, Lambert, Sangster, Noel and Campbell titled "Perceptions of discrimination among persons with serious mental illness," found that more than half of the study group (949 participants out of 1,824), which consisted of people who had been diagnosed with a serious mental illness, reported some experience with discrimination. The most common targets of this discrimination were mental disability, race, sexual orientation, and physical disability. Discrimination frequently occurred in employment, housing, and interactions with law enforcement. The study concluded that anti-stigma programs need to target not only discrimination related to mental illness but also that associated with other group characteristics such as race, gender, sexual orientation, and physical disability (Corrigan, Thompson, Lambert, Sangster, Noel & Campbell, 2003).

1.2 Context and Background

The Beginning: Bringing Gender Into the Equation With Regard to Mental Health in Canada

Twenty-four years ago the Canadian Mental Health Association's Women and Mental Health Committee published a ground-breaking report titled, *Women and Mental Health in Canada: Strategies for Change*. The historical report included 25 recommendations to help "remedy the serious gaps in knowledge and understanding about women's mental health problems" (Women and Mental Health Committee, 1987, p. 93). Central to the report was the idea that significant improvements in women's health and well-being could only be achieved if there were general gains in the status of women in education, employment and representation in decision-making roles. This meant that actions towards improving women's mental health would need to be integrated and co-ordinated with efforts to improve women's social status (Women and Mental Health Committee, 1987). In the report it was proposed that: 1) women should be more active participants in the process of developing mental health programs at every level; 2) that activities created to improve women's mental health should be integrated into the mainstream of general health-related programs; and, 3) that mental health programs should avoid exploiting the voluntary nature of much of women's health care work for others (Women and Mental Health Committee, 1987). Recommendations put forth by the Canadian Mental Health Association's Women and Mental Health Committee included (to name a few):

- Women's mental health should be made a priority by national and provincial agencies that fund research in the area of mental health;
- Health and Welfare Canada should develop appropriate materials for the promotion of information about women and mental health for dissemination to programs involved in the training of health and mental health professionals;
- Coverage of information on women and mental health should be included as a criterion for the accreditation of all programs involved in the training of health and mental health professionals;
- Workshops should be held in various locations in Canada for the purpose of informing mental health professionals, administrators and policy developers about issues related to women and mental health; and
- A national clearinghouse should be established for the collection and dissemination of research findings on women and mental health as well as information about programs developed to meet women's mental health needs.

(Women and Mental Health Committee, 1987).

The Canadian Mental Health Association's Women and Mental Health Committee was disbanded a long time ago, and the report has since disappeared from their website. No equivalent committee has been formed to address gender and mental health within the Canadian Mental Health Association.

But the importance of considering gender when discussing health in Canada has not lost momentum nor fallen on deaf ears since the Canadian Mental Health Association's

1987 report. In 2000, the federal government approved the *Agenda for Gender Equality*, an initiative which included new policies and programs and the accelerated implementation of commitments to include gender-based analysis. Health Canada's commitment to gender-based analysis was expressed in the *Women's Health Strategy* (1999) and *Gender-Based Analysis Policy* (2000). The Canadian Institutes of Health Research also began to require the application of sex- and gender-based analysis on the basis that it is "good science, ethical and essential to equity" (2010).

Yet despite the Canadian Mental Health Association's 1987 report and the federal government's policies and programs, as well as a wealth of other literature emphasizing the importance of examining mental health in Canada from a gender-based perspective (including the World Health Organization's *Integrating Gender Perspectives in the Work of WHO*, 2002), a sex- and gender-based analysis has not been reflected in recent reports on mental health in Canada. None of the large-scale Canadian reports such as the Romanow Commission's *Final Report on the Future of Health Care in Canada* (2002), the Standing Senate Committee on Social Affairs, Science and Technology's *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2005), and the Mental Health Commission of Canada's *A Time for Action: Tackling Stigma and Discrimination* (2008) have involved a sex- and gender-based analysis of mental health in Canada. Even the Mental Health Commission of Canada's draft framework for a national mental health strategy, published in 2009 — a 58-page document — mentioned gender only once, as more of a secondary consideration when looking at mental health in Canada (comparing gender to having the same impact on an

individual's mental health as location). When Michael Kirby, Chair of the Mental Health Commission of Canada, was asked about the lack of gender analysis in the work of the Commission at a stakeholder's conference in Victoria, British Columbia, he responded that the Commission could not consider all things, including Francophones (likening gender to having the same impact on an individual as language) (2009).

The Mental Health Commission of Canada and the Women's Health Movement

The Mental Health Commission of Canada evolved from a key recommendation of the 2006 report of the Standing Senate Committee on Social Affairs, Science and Technology titled, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. The report outlined the need for a mental health commission in Canada to provide an ongoing national focus on mental health issues. In March 2007, the federal government established the Mental Health Commission of Canada, committing $10 million for two years, and then $15 million per year starting in 2009-2010. The Commission, an arm's length, not-for-profit organization, would be in charge of three key initiatives: to develop a national mental health strategy, an anti-stigma campaign, and a knowledge exchange centre. In the spring of 2009, two more initiatives were announced: a national homelessness research initiative, and Partners for Mental Health, a program aimed at building a national movement around mental health and mental illness. The Commission also created eight advisory committees with experts from across Canada in the areas of:

- Service systems

- Science
- Family caregivers
- Mental health and the law
- Workforce
- Children and youth
- First Nations
- Inuit and Métis
- Seniors

The Commission itself does not provide services, but rather is seen as a "catalyst to help bring about action for reform, such as promoting collaboration amongst mental health agencies that are working in isolation from one another, to help them meet their common goals effectively" (Mental Health Commission of Canada, 2009). This means that the Commission has no political power to enforce changes or create mandates for provincial and federal governments with regard to mental health care — it can only make recommendations to provincial and federal governments.

The report out of which the Commission grew, and the Mental Health Commission of Canada itself, has drawn great criticism from the Canadian women's health movement with regard to the lack of concern for sex and gender in their work. Prior to the tabling of the Standing Senate Committee's report in May 2006, and in response to interim reports tabled in 2005, a national women's health organization, the

Canadian Women's Health Network, helped form the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions in Canada. This working group produced a background paper urging the Standing Senate Committee to use a sex- and gender-based analysis in their work. The Ad Hoc Working Group's policy backgrounder, titled *Women, Mental Health, Mental Illness and Addiction in Canada: An Overview* (2006, revised 2008) looked at why sex and gender matter when discussing mental health, mental illness and addictions in Canada, and provided factsheets about such topics as women and mental health promotion, women and trauma, women and psychotropic drugs, Aboriginal women and mental health, and the impact of immigration and settlement on women's mental health.

The announcement of the establishment of the Mental Health Commission of Canada in 2007 once again gave the Ad Hoc Working Group, with its growing number of members, another opportunity to engage. Experts, researchers, non-governmental organization (NGO) representatives, front-line community workers in the field of women's mental health, mental illness and addiction, as well as mental healthcare consumers from across Canada met on October 15, 2007 and October 16, 2007 at Carleton University in Ottawa, Canada, to discuss the need for a sex- and gender-based analysis in the work of the newly-established Mental Health Commission of Canada. The goal of the conference was fourfold:

1. To enable participants to learn more about the Mental Health Commission of Canada;

2. To discuss a strategy on how best to engage and inform the work of the Commission;

3. To start exploring the sex and gender aspects of a few of the key initiatives of the Commission; and

4. To continue to develop the Working Group.

Presenters at the *Women, Gender and Mental Health Conference* included: Howard Chodos, then Chief of Staff of the Mental Health Commission of Canada (now Director of the National Mental Health Strategy initiative for the Commission) and lead writer of *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addictions Services in Canada*; Madeleine Dion Stout, Aboriginal Health and Development Consultant and member of the Board of Directors of the Commission; and, Marina Morrow, assistant professor, Faculty of Health, Simon Fraser University.

Participants were asked at the conference, "What experience have you had in your work in applying a sex- and gender-based analysis?", to which a fervent discussion ensued. A few of the topic areas addressed by participants included:

- The need for trauma to be addressed in the work of the Commission;
- The importance of acknowledging the co-factoring of mental illness and addiction;
- The social determinants of health;

- The disconnect between anti-drug policies and the desire for an anti-stigma campaign (i.e. how federal policy may conflict with recommendations in the report with regard to criminalizing those living with addictions);
- The idea of dis-ease rather than disease (e.g. if an individual diagnosed as an alcoholic is genetically predisposed to alcoholism, or whether it is a result of their experiences of trauma, a dis-ease with their environment — or a combination of both);
- The stigma associated with pregnant women and substance use;
- The need for a variety of treatment options;
- The over-prescribing of psychotropic drugs to women;
- The challenges faced by immigrant women trying to access mental health services;
- The paradigm shift in what we define as mental illness;
- The structure and accountability of the Commission;
- The impact of being diagnosed with a mental illness and labelled as mentally ill; and,
- The barriers to accessing mental health services as well as defining mental health services in a much broader way to include such services as childcare.

Out of this conference, the Ad Hoc Working Group, through the Canadian Women's Health Network, created a letter and background paper for the Mental Health Commission of Canada recommending that a sex-, gender- and equity-based analysis be applied to all areas of programming and policy development undertaken by the Commission. Members of the Canadian Women's Health Network have since attended important stakeholder conferences held by the Mental Health Commission of Canada with regard to their draft framework for a national mental health strategy. The Commission, though agreeing that gender roles and responsibilities have a significant impact on mental health, declined the Canadian Women's Health Network's offer to become a sex and gender research node for the national knowledge exchange centre. There also continues to be a lack of any sort of sex-, gender- and equity-based analysis in the work of the Commission to this day.

1.3 Research Focus and Questions

The Canadian Women's Health Network was established in 1993 as a national, bilingual, non-profit organization dedicated to improving the health and well-being of girls and women across Canada through the collection, production, distribution and sharing of knowledge, ideas, education, information, resources, and strategies. It consists of a wide network of researchers and activists, including people working in community clinics, in hospitals, in universities, in provincial and federal health ministries, as well as in women's organizations across the country. The organization works with Centres of Excellence for Women's Health in universities across Canada (including the British

Columbia Centre of Excellence for Women's Health, the Atlantic Centre of Excellence for Women's Health, the Prairie Women's Health Centre of Excellence, the National Network on Environments and Women's Health, etc.). The Canadian Women's Health Network's vision statement includes the idea that:

> ***Health is a human right*** *that, because of poverty, politics and dwindling resources for health and social services, eludes many women. Guided by a woman-centred, holistic vision of women's health, the CWHN [Canadian Women's Health Network] recognizes and respects the diverse realities of women's lives and takes an active stance in ending discrimination based on gender, region, race, age, language, religion, sexual orientation or ability.*
>
> *(Canadian Women's Health Network, 2009)*

According to the Canadian Women's Health Network, the organization's main goals include: 1) helping to establish a visible national presence for women's health in Canada; 2) working to change inequitable health policies and practices; 3) providing easy access to reliable women's health information, resources and research; 4) producing user-friendly materials and resources; 5) promoting and developing links to information and action networks; 6) acting as a knowledge broker between and among researchers, clinicians, decision-makers, women and the public; 7) contributing women's voices and expertise to health research, planning and policy; 8) acting as a forum for critical debate on women's health research and policy issues; 9) monitoring emerging issues and trends affecting women's health; 10) encouraging community-based participatory research; and, 11) serving as a vital information link between women and Canada's health system (2009).

In January 2007, I began to work for the Canadian Women's Health Network in Winnipeg, Manitoba. I worked for two and a half years with this organization as their Information Centre Coordinator and Policy Analyst Writer. Due to my previous work in women's shelters in Montreal, Quebec and the rape crisis centre in St. John's, Newfoundland, as well as my work surrounding trauma, child sexual abuse, mental illness and addictions, I was given the responsibility of looking after the mental health file at the Network. This responsibility included organizing the *Women, Gender and Mental Health Conference* with the *Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions in Canada* in Ottawa in the fall of 2007. It also included working with partners and experts in the field of women's mental health across Canada to write background papers and letters to the Mental Health Commission of Canada, attending stakeholder conferences held by the Commission with regard to their national strategy on mental health in order to advocate for the inclusion of a sex- and gender-based analysis in their work, and meeting with the Chief of Staff of the Commission, Howard Chodos, to discuss the consequences if the Commission ignored sex and gender in their work. I also wrote several articles for the Canadian Women's Health Network's magazine, aptly titled *Network* magazine, on the lack of sex and gender in the work of the Mental Health Commission of Canada.

During this time, I became aware of the Mental Health Commission of Canada's anti-stigma campaign, *Opening Minds,* and became increasingly concerned with the direction in which the Commission was going with the initiative. Mainly due to my own personal experiences of trauma and mental illness, something about the Commission's anti-stigma

work did not sit well with me. To me, the initiative was not getting to the heart of the issue including issues of power and powerlessness. I became concerned that the Commission would be using large amounts of public health dollars to fund an initiative that essentially repeated the same mistakes of the past. My underlying concern was that there would be very little impact, if any, to Canadians' attitudes and behaviours towards individuals who are diagnosed with a mental illness and labelled as mentally ill.

Research has demonstrated that public attitudes and behaviours towards individuals who are diagnosed with a mental illness and labelled as mentally ill are extraordinarily resistant to change. The majority of anti-stigma campaigns have gone unevaluated as far as their long-term effects on people's attitudes and behaviours towards those diagnosed with a mental illness and labelled as mentally ill. As discussed above, what often is overlooked in the planning and development of anti-stigma campaigns is that stigma is dependent upon social, political and economic power. Link and Phelan write in "Conceptualizing Stigma," that oftentimes the role of power with regard to stigma is overlooked because in many instances "power differences are so taken for granted as to seem unproblematic" (2001, p. 375).

The Canadian Women's Health Network and the greater women's health movement have helped pave the way for greater questioning of the link between sex, gender and the stigma associated with mental illness. They have accomplished this through their ongoing research, publications, conferences and webinars, as well as attempts to engage the Mental Health Commission of Canada whenever the opportunity arises. The movement has also helped begin to expose the many layers and intricacies of

this form of discrimination and has started to bring more attention to the role that power plays in the process of stigmatization. This line of questioning beckons us all, including the Mental Health Commission of Canada, to dig a little deeper, as the meaningful recovery of individuals diagnosed with a mental illness and labelled as mentally ill depends upon this level of inquiry.

Power

> *"We must not understand the exercise of power as pure violence or strict coercion. Power consists in complex relations: these relations involve a set of rational techniques, and the efficiency of these techniques is due to a subtle integration of coercion-technologies and self-technologies. " (Foucault, 1993).*

In *Discipline and Punish: The birth of the prison* (1977), Foucault writes that unlike ancient societies, where power usually tended to reside with one person, and was localized and unitary in nature (i.e. was normally linked to an aristocracy that was able to control individuals from lower classes who had less influence), in modern societies there exists a dispersed system of power. He explains that, over time, as societies became more complex, so too, did systems of government, and with this came sophisticated and devolved models of power (Oliver, 2010). In medieval times, there was a highly individualized concept of the person, but in the modern period, explains Foucault, there was a greater tendency to categorize, organize and regulate people, with the expectation that people would act as a group and not as individuals (Foucault, 1977). Foucault wrote that by the end of the eighteenth century, the structure and nature of society had begun to

change and society became more organized and regulated (1977). Members of the public were subject to closer observation by administrative and governmental authorities (1977). Police forces were developed to monitor the citizenry, placing anyone who transgressed and violated the social norms set out by those in power into confinement (1977). An extensive system of observation would become one of the major ways in which society would know whether individuals were subscribing to the required norms of behaviour.

Foucault writes that the principal means by which power is exercised and the key characteristic of contemporary life is that of observation and monitoring of the individual (1977). He argued that we are all observed, in a variety of situations, every day. It is impossible to avoid being monitored, both our bodies and our minds, and Foucault wrote that this is the major manifestation of power in modern times. One must be willing to submit oneself to this observation, and the State ensures its capability of carrying out this observation through a variety of complex and carefully controlled administrative mechanisms (Oliver, 2010). Foucault points out the enormous power that is accrued by those individuals who conduct observations of individuals in society (1977).

In *Discipline and Punish* (1977), Foucault discussed Jeremy Bentham's concept of the Panopticon prison — a type of prison designed in the late eighteenth century that reflected the prevailing ideology of scientific structured observation. The idea behind the prison design was to have the maximum number of prisoners to be confined and monitored by the minimum amount of observers. The windows in the central tower would be tinted, so prisoners never knew how many people would be observing them, but

the psychological effect was that they felt they were being monitored all the time. Foucault pointed out that the Panopticon design set out to create internally within the individual the same type of atmosphere that the state wanted to create externally in society — that of citizens feeling as though they are being monitored or observed at all times. This in turn created the need to conform to society's social norms and values at all times. Foucault writes that prisoners were also categorized and documented in order to be better observed and monitored. He explained how this type of psychological observation and monitoring was extended by the state to other infrastructures, such as schools and hospitals.

With regard to mental illness, in *Madness and Civilization*: *A history of insanity in the age of reason* (1971), Foucault writes about society's need for stability, and how society creates institutions to address the situation of individuals who do not conform to social norms, such is the case with those individuals labelled as mentally ill. Foucault discusses the history of the ever-changing concept of 'insanity' from medieval times, when individuals labelled as 'insane' were perceived as holding a different way of seeing the world, but were not seen as a threat to society; to modern times where individuals labelled as 'mentally ill' are seen as cognitively deficient and a threat to the stability of society. Foucault argues that the concept of 'insanity' is, in fact, a social production that depends upon the attitudes of society at any particular moment of time in history (Oliver, 2010).

Foucault wrote that just like those who observe and monitor prisoners in Bentham's Panopticon design, individuals who work in psychiatry accrue a large amount of power, given their ability to decide what makes an individual ''insane' and what makes an individual 'sane.'

The Construction of Gender and the Stigma Associated with Mental Illness and Addiction

But what does this have to do with gender? Feminist post-structuralist theorist Judith Butler, writes in *Gender Trouble: Feminism and the Subversion of Identity* (1999) that gender is an unstable category, a social production much like the categories of "sane" and "insane." Butler writes that gender is something we "do" rather than something we "are." She argues in *Bodies That Matter: On the Discursive Limits of "Sex"* (1993), that there is nothing "natural" about the category of gender at all. Butler writes that gender is a discursive construct that is constrained by the power structures in which it is located (Butler, 1999).

The Category of "Gender"

Butler calls into question the category of the "subject" in *Gender Trouble* (1999), arguing that the subject is a performative construct. She disagrees with the idea Hegel puts forth in *Phenomenology of Spirit* (1807) — that the subject is a pre-existing metaphysical journeyer. In *Phenomenology of Spirit*, Hegel describes a 'Spirit' (meant to

refer to the subject) who, despite encountering numerous obstacles and setbacks along its journey towards absolute knowledge, continues and is motivated by the sheer desire for recognition and self-consciousness. Butler proposes something different — the subject is more of a "subject-in-process" (1999, p. 109).

Butler writes that gender identity is a sequence of acts with no pre-existing performer who does those acts, "no doer being the deed" (1999, p. 181). What this means is that unlike an actor who walks upon a stage and takes up a role, (a concept known as "performance"), say for example, an actor who takes up the role of a girl, Butler proposes that there is no pre-existing subject, the subject is constituted by the acts it performs (a concept known as "performativity"). Therefore, at birth, one does not exist as a subject until the doctor exclaims "it's a girl!" or "it's a boy!" A subject then begins to act following the social norms of behaviour linked to whichever gender category has been proclaimed. Butler writes that there are ways of "doing" one's identity —all of this causes problems for individuals with a vested interest in preserving the essentialized concepts of "male" and "female," "masculine" and "feminine," "gay" and "straight." As discussed above, the State has a vested interest in maintaining the illusion of stability of such categories, and therefore, any individual who is observed to be behaving in such a way that demonstrates the instability of gender categories, must be separated from the rest of society, and I will argue, in many cases, labelled as mentally ill.

Butler writes that "all gender is, by definition "unnatural" — meaning that there is not necessarily a relationship between one's body (sex) and one's gender, therefore, an

individual can have what has been designated as a "female" body and not display what has been designated as "feminine" traits and an individual can have what has been designated as a "male" body and not display what has been designated as "masculine" traits (1999, p. 49).

Melancholia

When it comes to gender identity, Butler borrows from Freud's psychoanalysis of loss and ego-formation found in *Mourning and Melancholia* (1917). Freud theorizes that in the process of ego-formation, an infant desires one parent (either mother or father), but because of the taboo surrounding incest, these desires have to be given up (Butler, 1999). The loss of this desired parent causes melancholia within the child, which in turn makes the child take the lost object (the desired parent) into themselves, the ego introjecting and preserving this object through identification (Butler, 1999). It is worthy of note that "introjecting" means "the unconscious psychic process by which a person incorporates into his or her own psychic apparatus the characteristics of another person or object" (Butler, 1999, p. 78). But Butler (1999) puts a twist on Freud's explanation of ego formation — she insists that the child's primary desire is always for the parent of the same sex, and therefore the taboo against incest is preceded by the taboo of homosexuality. Therefore a girl will desire her mother, but the taboo of homosexuality will mean the desire is disavowed, triggering melancholia which subsequently causes the girl to identify with the mother through incorporation — this type of internalization coming out as what has been designated as "femininity" (Butler, 1999). Therefore, Butler

(1999) believes that gender and sex identities are formed in response to prohibition. She asserts that "gender identity appears primarily to be the internalization of a prohibition that proves to be formative of identity" (Butler, 1999, p. 63).

> *If feminine and masculine dispositions are the result of the effective internalization...and if the melancholic answer to the loss of the same-sexed object is ideal, then gender identity appears primarily to be the internalization of a prohibition that proves to be formative of identity. Further this identity is constructed and maintained by the consistent application of this taboo, not only in the stylization of the body in compliance with discrete categories of sex but in the production and 'disposition' of sexual desire...dispositions are not the primary sexual facts of the psyche, but produced effects of a law imposed by culture and by the complicitous and transvaluating acts of the ego ideal.*
>
> *(Butler, 1999, p. 63-64)*

Butler (1999) writes that if heterosexual gender identity is formed from the primary loss of the same-sex parent (who is the object of the child's desire), than heterosexual gender identity is melancholic. She claims that melancholic identification takes place on the surface of the body (meaning it is incorporated).

> *Gender identity would be established through a refusal of loss on or in the body and so appears as the facticity of the body, the means by which the body comes to bear 'sex' as its literal truth.*
>
> *(Butler, 1999 p. 68)*

This means, "you are what you desired (and are no longer permitted to desire)" (Salih, 2003, p. 58). Butler (1999) writes that rigid gender boundaries conceal the loss of an original, unacknowledged, and unresolved love.

The Category of "Sex"

With regard to the category of "sex," Butler writes that the science that discusses chromosomal variations (i.e. XX-female and XY-male) exists within a heterosexual matrix — that "cultural assumptions regarding the relative status of men and women and the binary relation of gender itself frame and focus the research into sex-determination" (1999, p. 139). This means that the categories of "male" and "female" pre-exist and both frame and focus medical research hypotheses and questions, so that results will always uphold the two binaries. Accordingly, sets of attributes that have no relation to one another are classified as either "female" or "male." Butler argues that "sex," just like "gender," is a discursive category that, "imposes an artificial unity on an otherwise discontinuous set of attributes" (1999, p. 146). When science comes across an individual who has both sets of attributes, such as in the case of individuals who have reproductive organs associated with both female and male sexes (individuals labelled as "intersexed"), and who do not fall neatly into the two binary categories, such individuals are classified in the medical world as an "anomaly" or "abnormal."

Butler surmises that bodies are always gendered from the beginning of their social existence. Which occurs the moment a doctor or nurse proclaims "It's a boy!" or "It's a girl!". This proclamation is taken as natural, as fact, when it is, rather, a cultural inscription (1993). So gender becomes a process, a set of acts that exist within very tight boundaries that must constantly be policed, observed, or monitored by the state. Gender is constructed and constituted in discourse, and due to the complexity and dispersed

nature of power in contemporary society, is monitored and observed through numerous mechanisms including media, law, and social institutions such as health care, education etc. Individuals also become accustomed to monitoring themselves and others in the process.

Mental Illness, Addiction and the Associated Stigma

Foucault writes that all the mechanisms and techniques in which the State monitors and observes the bodies and minds of members of the public can render individuals increasingly more passive and malleable (1977). He writes that the awareness of the extensive power of the state to observe individuals creates a sense of powerlessness within individuals, a feeling that one has very little freedom, power and autonomy over one's life.

I will argue that behaviours that have been defined and categorized as mental illness and addiction are often responses to this sense of powerlessness and are developed in relation to the policing, observation, and monitoring of heterosexual gender norms (for example, sexual violence being used to preserve a supposed heterosexual gender order, which will be discussed further in chapter two). Responses to the trauma, violence and loss that are born out of the denial of the diversity and fluidity of gender are categorized as mental illness and/or addiction because the State does not want to reveal or expose its inadequacies. I will argue that the stigma against individuals diagnosed with a mental illness and/or addiction and labelled as mentally ill and/or addicts, in fact, uses the very same powerlessness against such individuals in order to continue to police, monitor,

observe and constitute heterosexual gender norms. An example of this would be the way research has demonstrated that a large proportion of women diagnosed with addictions issues are also survivors of childhood sexual violence, and the stigma associated with female addicts includes the negative stereotype that they are "sexually promiscuous" and "hypersexual," and therefore, in turn their bodies, as adults, become once again sites for sexual violence to occur with impunity.

In this thesis I investigate: 1) how stigma against individuals who are diagnosed with a mental illness and/or addiction is constituted by the powerlessness that occurs with the denial of the diversity and fluidity of gender and subsequent policing of rigid dualistic gender categories and constructs; 2) how this type of stigma in turn doubles the effects of this powerlessness, and doubles the aggression towards individuals diagnosed with a mental illness and/or addiction; and finally, 3) how this knowledge might inform strategies to combat the stigma associated with mental illness and addiction such as the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative, and what some alternatives to combating such stigma might be.

1.4 Approach and Method

I present a genealogical analysis of the ways in which institutions including media, law and health care facilities produce stigmatized identities with regard to mental illness for the purpose of policing heterosexual gender norms. Unlike a sex- and gender-based analysis, which according to Health Canada (2011), helps identify and clarify the differences between women and men and investigates how these differences affect health

status, as well as access to and interactions with health care institutions, a genealogical analysis does not assume that identities are self-evident and fixed, but rather that they are constructed by language and discourse (Salih, 2002, pgs. 10-11).

Oftentimes, research with regard to stigma against individuals diagnosed with a mental illness and labelled as mentally ill investigates what makes one person discriminate against another. But research has shown that using the standard model that asks "what-makes-person-A-discriminate-against-person-B" is inadequate and ineffective at explaining and understanding the full consequences of stigma processes (Link & Phelan, 2001, p. 372). This simplistic formula looks at whether person A's labelling and stereotyping of person B leads person A to engage in overt forms of discrimination directed at person B — for example, the *Opening Minds* anti-stigma initiative is trying to engage mental health care professionals to better understand their negative beliefs and attitudes towards mental health care consumers. Research has shown that "getting tangled up in the narrow intricacies of explaining a specific act from knowledge of a specific set of attitudes and beliefs could cloud rather than illuminate our understanding of why stigmatized groups experience so many disadvantages" (Link & Phelan, 2001, p. 372). Discrimination can exist outside of the model in which one person discriminates and treats another person badly —this is known as structural discrimination. Individuals diagnosed with a mental illness and labelled as mentally ill may face a myriad of accumulating institutional practices that work to disadvantage them even when individual prejudice and discrimination cannot be overtly observed.

In this thesis, I will investigate the links between power and knowledge generation. I will also look at how the production, monitoring and restraining of heterosexual gender norms plays a part in the conditions of emergence of both the labelling of individuals as mentally ill and/or addicts and the stigma associated with such labels. This will be done through an analysis defined by feminist post-structuralist, Judith Butler, (following the work of Foucault), as "genealogical" stating that it is "a mode of historical investigation that does not have 'the truth' or even knowledge as its goal" (Salih, 2002, pgs. 10-11). Butler explains,

> *'Genealogy' is not the history of events, but the enquiry into the conditions of emergence... of what is called history, a moment of emergence that is not finally distinguishable from fabrication.'*
>
> *(Revisiting Bodies and Pleasures, 1999, p. 15)*

In using a genealogical analysis, I will begin to peel back the layers of this type of stigma and reveal its deeper roots in the production, restraining and policing of heterosexual gender norms. I hope that this revelation will help to inform strategies being used to combat stigma against individuals diagnosed with a mental illness and/or addiction and help to build alternative methods for combating such stigma.

1.5 Significance and Importance

Statistics have shown that one in 10 Canadians (about 2.6 million people) aged 15 years and older have experienced symptoms consistent with alcohol or illicit drug dependence, major depression, mania disorder, panic disorder, agoraphobia, or social anxiety disorder (Statistics Canada, 2002). These same statistics have shown that only 32

per cent of Canadians who experienced symptoms consistent with mental health disorders or addictions issues tried accessing help. The majority refused to come forward because of the perceived stigma associated with mental illness and addictions (Statistics Canada, 2002). Based on the Canadian Medical Association's findings reported in their 2008 national report card on health care in Canada mentioned earlier, the pervasiveness of Canadians' negative attitudes and behaviours towards individuals diagnosed with a mental illness and/or addiction is a reality which can greatly impact the recovery and healing of individuals struggling with such melancholy.

As I mentioned earlier, there have been a myriad of anti-stigma campaigns of varying sizes (including national) launched in Canada over the last 60 years, and yet research demonstrates that negative attitudes and behaviours towards individuals diagnosed with a mental illness and/or addiction remain unchanged in this country. The Mental Health Commission of Canada appears to be following in the same footsteps as its predecessors in terms of the models and approaches being used for their anti-stigma initiative, they are in the process using large amounts of public health dollars.

And though there have been numerous documented commitments made by Health Canada and the Canadian Institutes of Health Research concerning the consideration of sex and gender in health research, there still remains a dearth of stigma research that actually looks at these categories. The Mental Health Commission of Canada has struggled with the consideration of sex and gender in their work. In a health stakeholder's conference in 2009, one of their policy analysts once asked what the difference is between sex and gender.

The Canadian women's health movement, including the Canadian Women's Health Network and the Centres of Excellence in Women's Health have, rightly, advocated for the Commission to consider sex and gender in their work. But I would argue that in order to unravel the unseen issues surrounding the stigma associated with mental illness and addiction, we must begin to examine the construction and instability of sex and gender categories and how such stigma is used to reinforce heterosexual gender norms.

What this means is there is a very real need for change not only in the negative perceptions held and the attitudes and behaviours exhibited by Canadians towards individuals living with mental illness and addiction issues, but in the strategies we are using to combat such stigmatizing views. I believe that my analysis may at once contribute to a broadening of the discussion and aid in envisioning a different approach to anti-stigma work done in Canada. I believe that this work will start a long overdue discussion, between individuals and communities, of the stigma associated with mental illness and addiction and its' link to heterosexual gender norms, creating possible roads towards meaningful recovery.

1.6 Limitations

Due to the complexity of the concept of stigma, there are, admittedly, limitations to my analysis. Firstly, according to Health Canada's Bureau of Women's Health and Gender Analysis, there is a dearth of stigma research using a sex- and gender-based analysis from which to draw. My work looks at two very specific cases: 1) the pathologization of gender variant identities; and 2) the stigma associated with female

addicts. Investigating the pathologization of gender variant identities will help to demonstrate the association between the ways in which mental illness is defined and the constituting, producing, restraining and policing of heterosexual gender norms. Looking at the stigma associated with female addicts will help to demonstrate how responses to powerlessness incurred by the instability of gender categories are stigmatized using the very same powerlessness against women living with substance-use issues. This is but a snapshot of the concerns surrounding mental illness stigma.

1.7 Overview of Subsequent Chapters

In chapter two, I investigate how mental illness is defined, and what models are currently being used to classify and categorize certain behaviours. I also look at the complexity of the concept of stigma and its relationship to power. I examine the common approaches being used in anti-stigma initiatives, including which approaches work and which approaches have not been proven to work. Throughout this chapter I examine the association between how mental illness is defined, and the restraining and policing of heterosexual gender norms.

In chapter three, I elaborate on my examination of the association between how mental illness is defined and the restraining and policing of heterosexual gender norms. I look at how certain identities that do not fit neatly into the proscribed categories of girl and boy, woman and man, female and male, such as gender variant or transgender identities, are pathologized. I then investigate the implications for anti-stigma campaigns such as the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative.

Though it may not be apparent at first, the pathologization of natural human diversity has large implications with regard to anti-stigma campaigns in Canada because through the process of pathologizing natural aspects of human diversity, certain identities become doubly stigmatized.

In chapter four, I continue to investigate how stigma related to addictions is associated with heterosexual gender norms. I look specifically at the stigma associated with women who are struggling with addictions issues. In the first half of the chapter, I look at how addictions issues are often a response to the powerlessness incurred by gendered violence and the instability of gender categories. Here too I explore how the stigma associated with female addicts uses the very same powerlessness against women living with substance-use issues. I look at the consequences of this stigma, how the bodies of women living with addictions issues often become spaces where violence can occur with impunity. Within this analysis, I look at how power structures produce such stigmatized identities in order to police and restrain heterosexual gender norms, and conceal the instability of gender categories. In the second half of the chapter, I look specifically at the stigma associated with pregnant and mothering women with substance-use issues, and how power structures such as media, law and health care institutions help to produce and police the tight confines of gender categories, in particular the concept of "good mothers" and "bad mothers." I conclude the chapter by looking at ways in which women may resist taking up the label of addict and its associated stigma.

In the fifth and final chapter, I present recommendations and considerations (based on the revelations found in the previous chapters) for anti-stigma campaigns such

as the Mental Health Commission of Canada's *Opening Minds* initiative. I look at alternative ways for individuals to take up the labels of "mentally ill" and "addict." I examine the necessity of addressing issues of trauma in anti-stigma campaigns as well as challenging the production of prohibited identities.

Chapter 2 Defining Mental Illness, Investigating the Stigma Process and Examining Anti-Stigma Campaigns

> "Given the negative perceptions of mental illness, and the shame, it is not surprising that people with mental disorders delay seeking help for decades," Hinshaw says. "Concealment remains a major means of coping."
>
> (Anwar, 2007)

Stephen Hinshaw writes in his book, *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*, (2007) that human fears of individuals perceived as "abnormal," threaten society's stability and survival. This, he says, combined with extreme and sensationalist media portrayals of individuals diagnosed with a mental illness and/or addiction, and the failure of politicians and the health care industry to give equal rights to individuals labelled as mentally ill and/or addicts, all work to stigmatize such individuals. Hinshaw writes from a very personal space, his own father's silent struggle with bipolar disorder which was often misdiagnosed or silenced because of the stigma associated with mental illness. As discussed in the previous chapter, the stigma against men labelled as mentally ill is oftentimes far stronger than for women. If men's responses to trauma, violence and loss are diagnosed as mental illness, oftentimes the associated stigma is that they are "weak," "fragile," and "emotional." This links mental illness in men to traits that have been associated with women.

Even I, who have the privilege of now knowing the sweet bliss and peace of recovery and healing from depression, am still well aware of the fact that I dread bringing up my past melancholy with anyone, even those closest to me. This perspective, of

course, informs my analysis, as in this chapter I begin to examine the ways in which people define mental illness, and the relationship of stigma to power. I investigate the good, the bad and the ugly of the differing approaches used in anti-stigma initiatives. I begin the discussion, which I pursue in subsequent chapters, of the association between how mental illness is defined (as well as the stigma associated with mental illness) and the producing, restraining, and policing of heterosexual gender norms. There are a myriad of ways in which the State can observe and monitor individuals' bodies and minds in order to ensure they conform to the accepted heterosexual gender norms. Whether in discourse, laws, policies, etc., our responses to such policing, and our feelings of powerlessness, are often defined as mental illness. The stigma associated with labels such as "mentally ill" and "addict" uses the same powerlessness to continue to push individuals to conform to heterosexual gender norms, in the process trying to conceal the very instability of gender categories.

2.1 Defining Mental Illness

The Canadian Medical Association's 2008 report card on health care revealed some alarming trends in Canadians' attitudes towards individuals who have been diagnosed with a mental illness and/or addiction and labelled as mentally ill and/or addicts. The eighth annual report surveyed Canadians to measure both their attitudes towards and experiences with the health-care system. What was uncovered was a myriad of negative views and attitudes espoused by Canadians towards individuals who have been diagnosed with a mental illness In light of these findings, the president of the

Canadian Medical Association likened mental illness to the "final frontier of socially-acceptable discrimination" (Sullivan, 2008).

The results found in the report were from an Ipsos Reid online survey of 2,024 Canadian adults. The survey revealed that only 50 per cent of Canadians questioned would tell a friend that a family member had been diagnosed with a mental illness (Sullivan, 2008). One in four respondents felt fearful of being around individuals who had been diagnosed as suffering from a serious mental illness (Sullivan, 2008). Fifty-five per cent of respondents said they would not marry someone who had been diagnosed with a mental illness (Sullivan, 2008). A solid majority of respondents would not see a family doctor (61 per cent) or hire a lawyer (58 per cent) who they knew had been diagnosed with a mental illness (Sullivan, 2008). With regard to the term "mental illness," 46 per cent of respondents thought it is often used as an "excuse for bad behaviour" (Sullivan, 2008).

To better understand why Canadians have adopted such stigmatizing views against individuals who have been diagnosed with a mental illness and/or addiction and labelled as mentally ill and/or addicts, we must first look at the ways in which people define and give meaning to the terms "mental illness," "mental disorder," and "mental dysfunction." Hinshaw (2007) suggests that there are seven models humans have used to define or give meaning to the term "mental illness." I look at each of the seven models for defining mental illness in order to further understand how responses to powerlessness are often defined as mental illness within the context of policing and restraining gender categories.

The Statistical Model

The first model of how people define or give meaning to the term "mental illness," is known as the "statistical model." This model contends that traits of both a physical nature (e.g. height, blood pressure, etc.) and of a psychological nature (e.g. depression, hyperactivity, etc.) are distributed throughout the population in the shape of a "normal curve" (Hinshaw, 2007, p.8). What this means with regard to traits of a psychological nature is that the majority of the population will usually group together in the middle of the distribution chart, and the few individuals who are at the extreme ends of the chart, are classified or categorized as people who exhibit "abnormal" behaviour. These individuals are consequently diagnosed with a mental illness.

The problem with the statistical model lies in the fact that the decision of where to draw the line in the chart with regard to what is defined as "normal" behaviour and what is defined as "abnormal" behaviour is completely arbitrary (Hinshaw, 2007; Anderson, 1995). It has been argued that a true "normal curve" is usually smooth as it moves towards the extremes on either side of the chart, and therefore, it is impossible to posit qualitative markers that would identify distinct segments of the population (Hinshaw, 2007) without pre-judging what behaviour qualifies as "normal" and what behaviour qualifies as "abnormal." What lies beneath the statistical model are social norms. These norms are subjectively defined behavioural expectations and cues concealed or disguised as objective, statistically valid scientific fact. I would argue that the selection of the two extremes, or what is defined as "abnormal" and "normal" behaviour, is already arbitrarily

decided upon before the very first population survey or calculation is made, and that this decision is governed by heterosexual gender norms.

There are labelling differences depending on whether individuals register on the extremes of statistical models about physical traits or on the extremes of statistical models about psychological traits. When looking at statistical models about physical traits, such as blood pressure for instance, individuals with blood pressure levels that are found on the extremes of the chart are labelled as people who *have* high or low blood pressure. But when we look at the statistical model with regard to psychological traits, such as depression, people who exhibit behaviours that are defined as being "abnormal" and hence are placed on the extremes of the chart, are diagnosed as *being* mentally ill. Therefore, the subject takes up the identity of *being* "mentally ill," oftentimes without resistance, as the arbitrarily-selected behaviours that are classified as "abnormal" are concealed as scientific fact.

Some may suggest, when looking at the statistical model, that the labelling of an individual as *being* "mentally ill" is a discursive process based on a set of discontinuous attributes, or rather behaviours upon which science helps to impose an artificial unity, thus making it appear "natural." What will be argued in later chapters is that many of the cultural assumptions that help define what is "normal" and "what is abnormal" are made within a heterosexual gender matrix. Assumptions concerning the stability of the categories of "boy" and "girl," "man" and "woman" and "male" and "female" help frame mental health and mental illness. This means that for individuals who do not fit neatly into the constructs of "boy" or "girl," "man" or "woman," "male" "female," their

subsequent responses to this type of powerlessness are classified as "abnormal." What will be argued in subsequent chapters is that the stigma associated with mental illness is based on the policing of these heterosexual gender norms, using the very same powerlessness it produces.

A final thought with regard to the statistical model and defining mental illness — Hinshaw points out that "traits that are seen as statistically deviant aren't necessarily impairing, dysfunctional or signs of a mental illness, whereas sometimes traits that fall in the "normal" range can be quite impairing and dysfunctional" (2007, pg. 9). An example of this is examined in chapter three when we discuss how individuals who identify as transgender are categorized in the Diagnostic and Statistical Manual of Mental Disorders as having a "Gender Identity Disorder," when there are many healthy, happy individuals who identify as transgender who might argue that they do not consider themselves as mentally disordered. Meanwhile, there are many individuals who work strictly within the confines of the constructs of gender who experience extreme levels of dysfunction trying to conform and keep within the very rigid boundaries of these categories, but would be classified as having good mental health.

The Social Deviance Model

A second model used to define mental illness is the social deviance model. This model like the statistical model is based on social norms, the concept that a group of people want to join as a social unit so they establish norms of behaviour. Any action that

violates these norms of behaviour or threatens the supposed "coherence" of the group is seen as "abnormal" or "deviant" (Hinshaw, 2007, pg. 9; Cumming & Cumming, 1965, p. 81). There is strong social pressure not only to observe the norms of behaviour decided upon by the group but also to point out any individuals who behave in a way that violates these norms. This conformity creates an atmosphere where a subject is both policing themselves and others. Individuals who violate these behavioural norms are relegated to a subgroup that is then labelled as "not belonging to" or as "outsiders" to the group that has decided what is "normal" and what is "abnormal." This "othering" is seen as a way of keeping people in line. Those individuals who violate the norms of behaviour are set apart by the group and from the group, and oftentimes they are isolated and punished (stigmatized). This stigmatization only helps to reinforce peoples' rule-abiding behaviour, which is seen as a way to preserve the cohesion of the group.

One of the most influential thinkers in the area of mental illness and social control is Michel Foucault. Foucault argued that the institutionalization of individuals diagnosed with a mental illness is a way of policing the public and ridding society of human difference (1977). He thought that involuntary confinement of the mentally ill helped to advance the State's regime of power based on what is perceived as "scientific truth" (this refers to the statistical model discussed above and its underlying relationship with social norms) (1980). Thus, when people respond to the denial of the instability of dualistic gender categories, perhaps through melancholia or substance use, these responses may be pathologized in order to maintain the illusion of stable heterosexual gender norms. These individuals are then labelled, singled out, separated and discriminated against. This

negative social response in turn sends a strong message to others to police both themselves and monitor and observe their neighbours.

The Moral Model

The moral model, sometimes also used to define mental illness, is considered as an extension of the social norms or social deviance model. The moral model argues that behaviours that violate social norms also violate ethical and moral codes. In the moral model, behaviours that go against social norms are not just perceived as "deviant" or "abnormal" but are also seen as "evil" and "bad." Hinshaw writes that the moral model is based on the perception that the source of immoral behaviour is one's possession by evil spirits or the devil (2007). Though one would think that possession by evil spirits would gain some sort of sympathy from others, in fact, the opposite is found with regard to the moral model. From this vantage point the individual is not absolved and is actually seen as morally weak, and responsible for the possession.

The moral model is often applied to addictions, and plays heavily in the stigma associated with substance-use problems. Individuals diagnosed with addictions are oftentimes perceived by society as being morally weak for being unable to quit and are held fully responsible for their substance-use problems. The stigma associated with women who use substances, in particular, includes the negative perception that female addicts are "sexually promiscuous," "hypersexual," "lacking morals" and "bad mothers." These assumptions point to the moral model of defining mental illness and addiction and

relate to strict definitions of acceptability, respectability, and femininity. The stigma associated with women who use substances is discussed further in chapter four.

Many individuals today still consider much of the behaviour that goes against proscribed social norms as immoral. This does not bode well for any anti-stigma campaigns that use the biomedical model of defining mental illness (discussed below). Hinshaw believes that if mental illness is defined in moral terms, then any sort of anti-stigma campaign that uses a biomedical model will not work. He points out further, "the strong tendency to make moral judgments about emotional and behavioral responses is a key consideration in any efforts to combat stigma" (2007, pg.11).

The Impairment Model

Another model that is sometimes used to define mental illness is the impairment model. According to the impairment model, it is not a statistical rarity, a violation of social norms, or a possession by an evil entity that defines mental illness but rather the level of impairment caused by behavioural patterns that go against social norms (Hinshaw, 2007). The impairment model looks at whether a person's behavioural patterns are causing significant problems for her or him in her or his everyday life. Possible questions used in this model in order to gauge the level an individual's impairment include: 1) Are the behavioural patterns affecting the individual's social life? 2) Are the behavioural patterns affecting the individual's employment? 3) Are the behavioural patterns affecting the individual's academic attainment? 4) Are the behavioural patterns

impacting the individual's relationships? and 5) Are the behavioural patterns in any way affecting the individual's general well-being?

One thing that is not considered in this model is the context and environment in which a person lives. Yet conditions of poverty, homelessness, unemployment, racism, classism, sexism, etc., all have an impact on an individual's life, and all have the ability to cause great impairment to the well-being of an individual. This begs the question: if an individual exhibits symptoms that are associated with the diagnosis of depression because they are living in poverty or experiencing multiple forms of discrimination, is it the depression that is causing the impairment, or the environment in which s/he lives? If an individual exhibits symptoms that are associated with the diagnosis of depression because they do not feel as though they fit into the rigidly defined gender categories of "woman" and "man," is it the depression that is causing the impairment, or the denial of the fluidity and instability of gender categories?

Another issue that is not addressed or considered in the impairment model is who defines impairment? Is it the individual her/himself who defines impairment and decides whether s/he is impaired? Is it the individual's caregiver who defines impairment and decides whether the person s/he is caring for is impaired? Or is it society that defines impairment and decides when an individual's behavioural patterns are causing her/him impairment? There are, undoubtedly, vast differences between what one individual perceives and defines as impairment and what another person perceives and defines as impairment (Mulvany, 2001). Lying beneath the rigid set of questions used in the impairment model to determine whether an individual's behavioural patterns cause

her/him impairment, are social norms. It can be argued that when an individual's behavioural patterns do not conform to the dualist heterosexual gender norms, these behaviours are determined to be impairing the individual, and the individual is labelled as mentally ill. As I mentioned in my discussion of the statistical model, it is often the case that behaviours which are arbitrarily defined as "abnormal" in terms of social norms, are in fact, not impairing at all. Nowhere in the impairment model is there room for people to decide whether they themselves believe that their behavioural patterns are an impediment to their own well-being.

The Biomedical Model

The fifth model, the biomedical model, is based on the medical perspective, and is the most predominantly used of all the models when it comes to defining mental illness in North America (Hinshaw, 2007). This model asserts that mental dysfunction comes from imbalances in bodily fluids, such as hormones or other neurological causes. What is defined as "abnormal" behaviour is considered a symptom of a problem within the body or brain. With a biomedical model, a comparison is often made between mental illnesses and physical illnesses — mental illness being likened to a disease of the brain.

Similar to the statistical model, behaviours that are defined as "abnormal" in the biomedical model and hence "a disease of the brain" are still based on social norms. Social norms help define what is "normal" behaviour and what is "deviant" or "abnormal" behaviour. In the biomedical model, social norms help inform mental health research questions so that what appears to be purely objective scientific fact, are really

social norms in disguise. These "scientific facts" are then used to inform health, as well as social and political policy-making thereby ultimately helping to police heterosexual gender norms. This process is evident in the pathologization of such natural processes as menstruation, with extreme premenstrual distress now being labelled as a mental illness known as "Premenstrual Dysphoric Disorder" (Caplan, 2008, p. 64). Categorization of this kind reinforces concepts and ideas that women are "emotionally unstable," "ruled by hormones," and reintroduces the very old negative perception that women are "hysterical."

The Harmful Dysfunction Model

Still another model for defining mental illness is the harmful dysfunction model. This model blends the social deviance model with the impairment model, and incorporates as well a more scientific perspective that has its roots in the biomedical model. Hinshaw writes that the harmful dysfunction model has incited a recent revival of efforts to define mental illness by scientific terms, similar to the biomedical model (2007).

The harmful dysfunction model asserts that behaviours that are defined as "abnormal" do not necessarily denote a mental illness unless these behaviours either: a) violate social norms; or b) cause a fair amount of impairment to the individual who exhibits these behaviours (Wakefield, 1992). According to this model, impairment (or harm) alone does not necessarily denote mental illness. For that diagnosis to occur there must also be a profound level of medical or neural problems detected. This means that,

according to the harmful dysfunction model, a mental illness is only present if there is an underlying dysfunction in the "mental mechanisms" of the brain.

When considering the harmful dysfunction model, as a way of defining mental illness, the question arises as to who and what defines healthy mental mechanisms of the brain? The argument can be made that even within complex models such as the harmful dysfunction model, social norms help define "normal" and "abnormal" behaviour and "healthy" and "unhealthy" brain mechanisms.

The Developmental Psychology Model

The last modelt to be looked at here is the developmental psychology model. According to the developmental psychology model, behaviour that is defined as mentally-disordered is not static but rather dynamic and fluid. According to the developmental psychology model, mentally-disordered behavioural patterns wax and wane over time and change in relation to an individual's social context; thus meaning that mental disturbances reveal themselves in phases and states (Baltes, Reese, & Lipsett, 1980).

Unlike the reductionist biological or social models of defining mental health, the developmental psychology model understands that mental disorders are not static entities. According to this model, behaviour that has been defined as "abnormal" doesn't simply emerge unexpectedly but rather individuals diagnosed with a mental illness will often shift from phases of what is defined as relatively "normal" and "healthy functioning" to

what is referred to as "psychopathology" and then back again. In other words, — the individual may transition between relapses and remissions.

In the developmental psychology model, mental illness is explained as a "complex, interactive array of personal and environmental influences that unfold across development to produce both healthy and adaptive functioning" (Hinshaw, 2007, p. 16). The developmental psychology model is informed by a diverse array of scientific fields including embryology and developmental psychology, and incorporates elements of the personal impairment/ecological perspective, the medical model and the harmful dysfunction model. The developmental psychology model also considers the emergence of mental disturbance from prior development states while emphasizing the continuous interplay of biological underpinnings and environmental contexts in such behaviour (Baltes, Reese, & Lipsett, 1980).

Although the developmental psychology model considers underlying biological predispositions, it contends that the social context in which an individual lives greatly influences symptoms and impairments. This model argues that people and their environment are mutually interactive.

The Positive Psychology Model

A model that should also be noted as it has been gaining traction in mental health services in Canada in recent years is the positive psychology model. Martin Seligman and Mihaly Csikszentmihalyi summarized the model in 1998, stating, "We believe that a psychology of positive human functioning will arise, which achieves a scientific

understanding and effective interventions to build thriving in individuals, families, and communities" (2000, p. 7). Psychologists using the positive psychology model seek to "find and nurture genius and talent," and "to make normal life more fulfilling," (Compton, p. 12) not simply to treat mental illness. Researchers in the field of positive psychology analyse states of pleasure or flow, values, strengths, virtues, and talents with the hopes of finding ways for institutions and social systems to promote such things (Peterson, 2009, p. 5). They are concerned about positive experiences, enduring psychological traits, positive relationships and positive institutions (Peterson, 2009, p. 6).

Models of Defining Mental Illness Used in Canada

As demonstrated above, there are a myriad of ways to define mental illness — but the most predominant models currently in use in Canada are the biomedical model, and less overtly, encouched in media and social discourse, the moral model. With regard to the biomedical model, psychologists, psychiatrists, physicians and clinicians trained in Canada use the Diagnostic and Statistical Manual of Mental Disorders IV (text-revised version) to diagnose patients. More than 900 pages long and listing over 365 disorders, this manual has checklists of symptoms for each disorder. Treatment for these disorders, for the most part, involves taking prescription pharmaceutical drugs. As discussed above with regard to the biomedical model, though there is an assertion that mental dysfunction is due to imbalances in bodily fluids, such as hormones, and hence, is a "disease of the brain" that can be treated with medication, behaviours that are defined as "abnormal" in the biomedical model are still based on social norms. This will be investigated further in

Chapter 3, when I look at the pathologization of gender variant identities in the Diagnostic and Statistical Manual of Mental Disorders. With regard to the moral model, in Chapter 4 I examine how Canadian media use a moral model to define addiction in pregnant and mothering women.

2.2 What is Stigma?

Although there has been a great increase in literature on the effects of stigma following Erving Goffman's book, *Stigma: Notes on the Management of Spoiled Identity* (1963), many would argue that the concept of stigma has since best been described by Bruce Link and Jo Phelan in *Conceptualizing Stigma* (2001). Link and Phelan (2001) write that stigma exists when four interrelated components (labelling, stereotyping, separation and status loss) converge. Below, I discuss these four interlinked components, and how they relate to the stigma associated with mental illness and addictions.

Distinguishing and Labelling Differences

Of their first component of stigma, distinguishing and labelling differences, Link and Phelan write, "there is a social selection of human differences when it comes to identifying differences that will matter socially" (2001, p. 367). They contend that once differences are identified and labelled, these differences are typically taken for granted as always having been there, or as "just the way things are" (2001, p. 367). With regard to mental illness, as mentioned above, social norms dictate what is defined as "normal" behaviour and what is defined as "abnormal" or "deviant" behaviour. Individuals who

exhibit behaviours that violate what has been deemed as "normal" behaviour are thus seen as different from the norm, as "abnormal," and are subsequently set apart from others and labelled as "mentally ill." Science and statistics conceal the arbitrariness of the social selection of what is defined as "normal" and "abnormal" behaviour by categorizing these behaviours exhibited by individuals as statistically rare. It thus appears as though the criteria for both diagnosing and defining what behaviours constitute a mental illness is based on science, on facts, and is "natural."

As mentioned in Chapter 1, Judith Butler writes in *Undoing Gender* (2004), that gender is seen as "natural" because of its embeddedness in social discourse, and the repetitiveness of the acts associated with the socially constructed category of gender. A constant social concern lies in maintaining the stability of these "natural" dualistic gender constructs, and in responding to any threats to that stability. One could argue that in order to maintain the perception of stability of heterosexual gender norms, anyone who behaves in a way that violates or threatens the socially-constructed categories of male and female is labelled "mentally ill." An example of this would be, as previously mentioned, individuals who identify as transgender being classified in the Diagnostic and Statistical Manual of Mental Disorders as mentally ill. Their diagnosis "gender identity disorder". And while there are many happy, healthy individuals who identify as transgender, individuals who want to avail of sex-reassignment surgery in Canada must first be diagnosed with gender identity disorder (this will be examined in further detail in Chapter 3). This supports the notion that individuals who may not fit neatly into one gender

category or the other are labelled as mentally ill, thereby reinforcing the stability of the dualistic gender category construct.

Another example of the pathologization of human difference, specifically the pathologization of the naturally occurring variation of human sexuality in order to police heterosexual gender norms, is that up until 1973 homosexuality was classified in the Diagnostic and Statistical Manual of Mental Disorders as a mental illness. This supports Butler's assertion that gender identity is primarily the internalization of a prohibition of a same-sex desire which proves to be formative of identity (Butler, 1999). Butler writes that gender identity is constructed and maintained by a consistent application of the taboo of homosexuality. The pathologization of homosexuality would in this sense serve as an attempt to conceal the instability of heterosexual gender norms. Though homosexuality has been removed from the Diagnostic and Statistical Manual of Mental Disorders, it was never entirely removed, with the creation of "ego-dystonic homosexuality disorder" in the third edition of the Manual, a diagnosis that still exists in the current, fourth edition (Lev, 2006). This will be discussed further in Chapter 3.

Link and Phelan write that it is the taken-for-granted nature of these categorizations that empowers them (2001). Butler says the same with regard to the construction of sex and gender categories. But some theorists point out that if we look closely enough, there are cracks in what is perceived as the "naturalness" of these categories that demonstrate their very constructedness. Link and Phelan write that there are things that demonstrate how constructed or "social" these social selections of differences are: for one thing, substantial oversimplification is required to create groups. In addition, the attributes

deemed salient differ dramatically according to time and place (2001). The latter, Foucault addressed in *Madness and Civilization* (1971), in reference to individuals labelled as mentally ill in medieval times who were regarded as individuals that had different world views, that should be listened to, and were considered no threat to the stability of society. In modern times, however, the concept of "insanity" has come to be defined as individuals who are perceived as cognitively deficient and a threat to society. In reference to this shift in social thinking, Link and Phelan observe that key critical sociological questions that need to be answered. These include: 1) how culturally-created categories arise and how they are sustained; 2) why some human differences are singled out and seen as salient while others are ignored; and 3) what the social, economic and cultural forces that maintain the focus on a particular human difference are (2001). I will attempt to answer some of these questions in the following chapters.

Associating Human Differences with Negative Attributes

Link and Phelan's second component of stigma is the association of human differences with negative attributes. This bridging of the two leads to negative stereotypes, such as men who are diagnosed with a mental illness and labelled as mentally ill are labelled emotionally weak and women who are diagnosed with an addiction and labelled as addicts are considered sexually promiscuous and morally lacking. The labels "mentally ill" and "addict" are thus linked to a set of undesirable characteristics that form a stereotype. As discussed in Chapter 1, the label of mental illness, when applied to men, has been linked to the negative perception that men

diagnosed with a mental disorder are weak, whereas the label of addict, when applied to women, has been linked to the negative perception that women who have been diagnosed with addictions issues are sexually promiscuous, have loose morals and are bad mothers. Research has begun to show that these types of negative stereotypes are used to make split second judgements, and appear to be working almost on a subconscious level, as they are imbedded in social discourse (Link & Phelan, 2001).

Separation

The third component of Link and Phelan's stigma process occurs when social labels indicate a separation of "us" from "them" (2001). The two preceding components, distinguishing and labelling differences then linking differences to undesirable attributes, become the rationale for believing that individuals who have been labelled are fundamentally different from individuals who don't share the same label.

The "not in my backyard" phenomenon, known as the "NIMBY" phenomenon, demonstrates this component as it relates to mental illness. As residential programs for individuals diagnosed with a mental illness seek to develop housing in neighbourhoods, and rehabilitation programs seek to find supportive employment opportunities, they have come up against the NIMBY phenomenon — where neighbourhoods and places of employment fight to deny access to these types of housing and supportive employment programs under the negative belief that all individuals diagnosed with a mental illness and labelled as mentally ill are dangerous (Link & Phelan, 2001).

> *...when labelled persons are believed to be distinctly different, stereotyping can be smoothly accomplished, because there is little harm in attributing all manner of bad characteristics to "them." In the extreme, the stigmatized person is thought to be so different from "us" as to be not really human. And again, in the extreme, all manner of horrific treatment of "them" becomes possible (Link & Phelan, 2001, p. 370).*

Even within the label itself, there is evidence of the effort to separate "us" from "them." As mentioned above, when an individual is diagnosed with a physical illness, it is often said that someone *has* an illness (e.g. one *has* diabetes, cancer, arthritis, etc.) but when someone is diagnosed with a mental illness or addiction, they are often perceived as *being* mentally ill (e.g. an alcoholic, a schizophrenic, a manic depressive, etc.)

Status Loss and Discrimination

The fourth and final component of Link and Phelan's stigma process is status loss and discrimination. The authors write that, "When people are labeled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting and excluding them" (2001, p. 370). The immediate result of negative labelling is the downward movement of an individual on the status hierarchy. Research has shown that stigmatized groups are disadvantaged when it comes to life opportunities such as income, education, psychological well-being, housing status, medical treatment, health, etc. (Druss et al., 2000). With regard to mental health, individuals labelled as mentally ill and/or addicts experience discrimination when it comes to housing, employment, access to appropriate health care, education, personal relationships, etc.

Imbalance of Power

As discussed in Chapter 1, power plays a pivotal role in stigma. Stigma is based on an imbalance of power, whereby people in positions of power are able to actively stigmatize others, unchecked, while victims of stigma must lack a sufficient amount of power and resources to oppose the loss of status. In the case of mental illness, some individuals who identify as mental health care consumers have joined together in recent years to advocate on behalf of those who have been diagnosed with a mental illness, and to bring attention to the need to change stigmatizing attitudes towards individuals who have been labelled as mentally ill.

But as mentioned above, it can be very difficult to change people's negative attitudes and behaviours towards individuals diagnosed with a mental illness and/or addiction, especially when negative stereotypes are formed by social norms. These social norms help shape discourse. For example, much mainstream media continues to reflect negative stereotypes of individuals living with a mental illness and/or addiction because it is said that mainstream media often reflect the values of those individuals in positions of power. Foucault writes that power, and those individuals who exercise it, have the capacity to create large-scale systems of thought that can exert a considerable amount of influence on people (Oliver, 2010). Yet there are also a growing number of examples of independent media beginning to reflect a different perspective. Some have even published unedited stories from the viewpoints of individuals who have experienced being diagnosed and labelled as mentally ill and/or addicts. Yet despite these and similar inroads mainstream media discourse continues to exert and influence programs and policies. The refusal in

many recovery programs to hold the system as partially responsible for the illness and the criminalization of individuals diagnosed with a mental illness and/or addictions issues, as well as discriminatory child welfare practices are but two examples. All of this points to the conclusion that it is very difficult to combat stigma against individuals diagnosed as having a mental illness and/or addictions issues, because it entails trying to change large-scale systems of thought exerted by those in power. What might be more effective is to expose the mode of functioning of power, and expose the nature of power.

2.3 Anti-Stigma Campaigns: Common Approaches and Associated Gender Implications

One of the Mental Health Commission of Canada's key initiatives is the implementation of a national anti-stigma campaign to help "educate Canadians about the reality of mental illness, with the ultimate goal of eliminating stigma and all forms of discrimination against people and families living with mental illness" (2009). The Commission suggests that an anti-stigma campaign will encourage individuals experiencing mental health difficulties to seek help, and will help to eliminate stigma against these individuals (2009). As discussed above, stigmatizing attitudes towards individuals diagnosed with a mental illness, according to recent research, are pervasive in Canadian society (Canadian Medical Association, 2008). Yet the Commission, it would appear, is using the same approach in their anti-stigma initiative that has been used by nearly a dozen anti-stigma campaigns that have been launched (with little success) throughout the last 60 years across Canada. This lack of success has been demonstrated

by resistance and by alarmingly high levels of stigmatizing attitudes and behaviours exhibited by Canadians in the Canadian Medical Association survey.

2.4 Effective Anti-Stigma Campaigns: Evidence of What Works and What Doesn't

There are three different approaches that the majority of anti-stigma campaigns tend to use: 1) the normalization approach; 2) the media and social attitudes approach; and 3) the rights-based approach (Smith, 2002). I look at the effectiveness of each of these types of approaches below.

The Normalization Approach

The normalization approach is the most frequently used approach in anti-stigma campaigns, with examples in England (i.e. the "Beyond Blue" campaign), Australia (i.e. the "Changing Minds" campaigns) and New Zealand (i.e. the "Like Minds, Like Mine" campaign). This approach emphasizes how common mental disorders are, and asserts that people diagnosed with a mental illness are "just like us," except that they have a genetic or medical difference. This approach uses a biomedical model to define mental illness. The normalization approach is based on achieving *acceptance* rather than *equality*, and criticism of the approach includes the fact that even people who may not be "just like us," who may, for instance, have a cognitive impairment as a result of schizophrenia, deserve to be treated in the same way as everyone else (Agic, 2003).

The unintended effect of anti-stigma campaigns using a normalization approach may, in fact, be an increase in stigma against individuals diagnosed with mental illness and labelled as mentally ill (Lauber, Carlos, & Wulf, 2005; Dietrich, Matschinger, & Angermeyer, 2006). Studies have shown that using biogenetic and biological explanations exclusively in anti-stigma campaigns was found to decrease the likelihood of social acceptance of people with schizophrenia and major depression (Dietrich, Beck, Bjantugs, Kenzine, Matschinger, & Angermeyer, 2004; Dietrich, Matschinger, & Angermeyer, 2006). A study looking at stigma against individuals living with schizophrenia found that anti-stigma campaigns which solely recommended pharmacological therapies were associated with greater social distancing (Lauber, Carlos, & Wulf, 2005).

While the normalization approach would appear on the surface to be a fair and inclusive approach, it has been argued that a more holistic approach to our understanding of mental illness, extending beyond biomedical models of defining mental illness, is necessary for truly effective anti-stigma campaigns (Smith, 2002).

The Information, Media and Social Attitudes Approach

The information, media and social attitudes approach is also commonly used by anti-stigma campaigns, as media is seen as having a powerful influence on mental health attitudes. This approach tries to use the media's intense interest in stories about mental illness to help spread an anti-stigma message, with the hopes of changing the public's negative perceptions. As discussed above, however, the problem with the information,

media and social attitudes approach is that research and media studies have long demonstrated that the concept of "objectivity," a key principle in journalistic professionalism involving fairness, factuality and non-partisanship, conceals the fact that power helps shape large-scale systems of thought and discourse. Power influences media as it produces and restrains social norms ((Bagdikian, 1983; Chomsky, 2002; Herman, & Chomsky, 1988; Kaplan, 2002; Mindich, 1998; Shudson, 1978; Shudson, 1997).

In the media social norms influence decisions concerning what stories and whose stories are considered "newsworthy." They also inform decisions concerning what stories and whose stories take priority. In addition, decisions about how to frame stories and decisions around how to market the news are influenced by social norms. Media also helps to produce and restrain heterosexual gender norms which are concealed under the guise of "journalistic objectivity." As a former journalist myself I can attest to the fact that , "objectivity," the idea that a journalist can witness an event, suspend all personal biases and judgments, and describe the event to readers in an impartial way, was the cornerstone of my education as a reporter. The problem is that social norms lie beneath every choice a journalist makes. The choice of words to use, the decision of who to interview and give a voice to, the choice of how to structure the story, and even the choice of what stories to report and what stories not to report are guided by social norms. Michael Smith writes, "Reporting a story in a way that failed to start from, or work with, existing attitudes is likely to be perceived as propaganda" (2002, p. 6). This means that it is difficult to change large-scale systems of thought created by power; which is what the information, media and social attitudes approach proposes to do. A more effective

approach might be to analyze the function of power. For example, the Media Awareness Network, a Canadian non-profit organization that works nationally to develop media literacy and digital literacy programs for youth, arms young people with the tools to decipher the messages that exist between the lines and to critically analyze such messages coming from mainstream media.

Research has demonstrated that anti-stigma campaigns that use the information, media and social attitudes approach have had disappointing results. They have shown that although short-term interventions using film and literature may change self-reported attitudes, there has been very little evidence of longer-term behavioural change (Smith, 2002). In Germany, as part of the "Open the Doors" anti-stigma campaign, it was found that a film portraying the experience of a young man living with schizophrenia actually reinforced negative stereotypes the audience members had against individuals diagnosed with schizophrenia (Gaebel & Baumann, 2003).

The Rights-Based Approach

The rights-based approach is the least commonly used approach in anti-stigma campaigns. This approach is based on the idea that people stigmatized because of mental illness and/or addiction issue are a group who are wrongfully shamed, humiliated and marginalized. It recognizes that this type of stigma is applied to other minorities as well. The rights-based approach seeks to counter discrimination by monitoring and enforcing equal access to health care, housing, employment and justice. This, in turn, leads to practical improvements for individuals diagnosed with a mental illness and/or addiction

issue and labelled as mentally ill and/or addicts not only in their daily lives, but also in their self-confidence and in terms of social inclusion (Smith, 2002).

The rights-based approach differs from the other two approaches, which are both focused on the individual and aim to combat stigma by either: a) aiming to increase knowledge or induce the empathy of individuals who stigmatize against people diagnosed with a mental illness and/or addiction issue; or b) improving the ability of individuals labelled as mentally ill and/or addicts to cope with stigma and discrimination. In contrast, the rights-based approach concentrates on reducing stigma at the institutional levels and structural levels, as stigma occurs within a power structure that facilitates and enables it. Examples of efforts to reduce stigma that have evolved out of a rights-based approach include: 1) community level mobilizing (i.e. demonstrating the power of resistance); 2) appropriate reporting and enforcement mechanisms (i.e. legal aid, hotlines to report discrimination, socially endorsing a rights-based approach); and 3) changes in legislation and policies to protect the rights of individuals diagnosed/labelled with a mental illness and/or addiction issue.

The rights-based approach also acknowledges the intersections of race, class, gender, sexual orientation, age, ability, and location, and that the type of stigma used against people diagnosed/labelled with a mental illness and /or addiction issue is also applied to other minorities. This means that issues surrounding the discrimination against individuals based on race, class, gender, sexual orientation, age, ability, and location must equally be considered in light of their implications and associations with the stigma levied against individuals labelled as mentally ill and/or addicts. It also means addressing

issues of poverty (including the lack of affordable housing and low minimum wages), racism, homophobia, lack of accessibility, etc. when looking at the association between stigma against individuals diagnosed with a mental illness and/or addiction issue and the production, restraining and policing of heterosexual gender norms.

While the rights-based approach requires major social and economic changes, and is thus the most challenging, it may lead to far deeper and more permanent change than the other two approaches (Smith, 2002). Few programs that address structural and institutional stigma are addressed in peer-reviewed literature. The Mental Health Commission of Canada has made it clear that they will not be using a rights-based approach in their work. Their national mental health strategy, for example, which states that the Commission will not be making recommendations with regard to increasing the number of low-income housing units or raising the minimum wage. Another example is the Mental Health Commission's hesitancy to address gender in any of their work so far, including their anti-stigma campaign.

2.5 The Mental Health Commission of Canada's Anti-Stigma Campaign

On October 2nd, 2009 the Commission launched *Opening Minds*, its 10-year anti-stigma/anti-discrimination initiative. This initiative is purportedly the largest anti-stigma initiative in Canadian history. In the first year of the initiative, the Commission chose to target two specific groups: youth aged 12 to 18 years and health care professionals.

The *Opening Minds* initiative began with a consensus meeting in September 2008, where a consensus vision statement and guiding principles were decided upon. Their

original draft of a vision statement, produced by a consensus group consisting of professionals and researchers in the field of mental health as well as mental health care consumers was:

> *The vision of the Canadian Mental health community is of a country where people with mental illnesses or disorders have the same rights and opportunities as all other citizens and are not subjected to stigma or discrimination in any form. (Mental Health Commission of Canada, 2008, p.3)*

According to the meeting report there was great debate over whether the term "mental illness," "mental disorders," or "mental health problems" should be used and why. Participants also discussed whether the focus should be shifted to emphasize the importance of mental health and wellness. The final consensus vision statement decided upon was:

> *We envision a Canadian society that values and promotes mental health and wellness and is free from discrimination. (Mental Health Commission of Canada, 2008, p. 3)*

The changes made to the vision statement demonstrate the direction in which the Mental Health Commission of Canada was and continues to go with their anti-stigma initiative. Note the removal of the statement "where people with mental illnesses or disorders have the same rights and opportunities as all other citizens." This deletion indicates a departure from a rights-based anti-stigma approach where everyone deserves the same rights, no matter what.

The Mental Health Commission of Canada's move away from a rights-based approach became even more apparent when the draft framework for a national mental health strategy for Canada was released by the Commission a year later, in 2009. This

draft stated, as mentioned above, that they would not be advocating or recommending an increase in low-income housing or an increase in the minimum wage. Instead, the committee's vision statement includes the very liberal concept of a "society that values and promotes mental health and wellness." Though it is important to live in a society that values and promotes mental health and wellness, this does not get to the heart of the stigmatization process (i.e. it does not address the issue of status loss and structural discrimination, and the overarching power imbalances that support the stigmatizing process).

In the guiding principles of the committee, evidence of the normalization approach is present, as the second guiding principle states that, "The initiative will support and encourage all Canadians to lead by example in accepting, including and respecting others" (Mental Health Commission of Canada, 2008). As discussed above, the normalization approach is about acceptance of others rather than the idea that everyone deserves the same rights, whether a person accepts another person or not.

Another guiding principle states that "The Commission will work collaboratively with the mental health community to inform the development and implementation of the Anti-stigma/Anti-discrimination Initiative, further its objectives and develop effective, broad-based messaging about stigma and discrimination." According to Smith, research has shown that broad-based messaging is ineffective in the long-term changing of negative attitudes towards individuals labelled as mentally ill and/or addicts (Smith, 2002). An example of this is Wang and colleagues' study which found that with regard to depression, broad-based strategies involving peer-based contact to combat stigma against

individuals diagnosed with depression only proved to be effective in women, and not men (2007).

Another guiding principle states that "The Commission will seek engagement with diverse partners including leaders, persons of influence and change agents in various sectors." When Howard Chodos, from the Mental Health Commission of Canada, presented to the Canadian Women's Health Network, he mentioned that the Commission had no problem in partnering with the pharmaceutical industry for such things as the anti-stigma campaign initiative. Pharmaceutical industries have a long history of supporting anti-stigma campaigns because one of the main goals of an anti-stigma campaign is to encourage people to get the proper mental health supports, including pharmaceutical treatments. Diagnosis means treatment and treatment means drugs. Research has shown that fewer than 10 per cent of psychiatrists in the United States offer psychotherapy (i.e. talk therapy) as a form of treatment anymore (Brown, July 9, 2011). Ian Brown writes in his article, "Where is its mind? What the battle over the 'bible' says about psychiatry," that "the alignment of pharmaceutical expertise with ever-more diagnostic categories, glued together by the medical-insurance industry, has completely changed the shape of North American mental health" (July 9, 2011). This is exemplified, Brown writes, by the fact that 10 per cent of boys in North America are taking medication for attention-deficit hyperactivity disorder, and that in the past decade the diagnosis of childhood bipolar disorder has risen at least forty fold (July 9, 2011). Brown writes,

> *"By the age of 32, half the people will have qualified for an anxiety disorder, 40 per cent for a depressive disorder," Dr Frances says... "Because of the power of drug-company marketing and the Internet and consumer-advocacy groups,*

> *there have been a number of false epidemics, of fads in psychiatric diagnosis that have resulted in tremendous diagnostic inflation and much higher rates of mental disorder than ever before. And many more people getting medication, which in many cases is not useful and may be harmful."*
>
> *(July 9, 2011)*

This brings about the question of whether the goals of an anti-stigma campaign are to combat the stigma against individuals living with mental illness or to increase the labelling of people as "mentally ill?" Perhaps the ties to pharmaceutical companies will mean that anti-stigma campaigns will choose to use a normalization approach rather than a rights-based approach, because a normalization approach is based on a biomedical model that puts forth the idea that mental illness is a disease of the brain that simply requires the taking of medication. This approach encourages individuals to come forward for treatment, whereas a rights-based anti-stigma campaign delves into the complexities of mental illness and stigma and the structural and institutional factors which support the stigma.

Another guiding principle of note includes, "The activities of the initiative will be informed by best/promising practices from research and lived experience and will incorporate lessons learned from evaluation." Contrary to the promise of this statement, when the Canadian Women's Health Network inquired about helping create a sex and gender node or hub to make up part of the Mental Health Commission of Canada's knowledge exchange centre, the Mental Health Commission of Canada politely declined the offer. Though research has demonstrated time and time again one must consider gender and sex when looking at mental illness and addiction in Canada, with the

Canadian Institutes of Health Research even stating that it is good science to do so, the Mental Health Commission of Canada continues to ignore sex and gender in their work.

One of the anti-stigma campaigns that the Mental Health Commission of Canada has been looking at as a model for their own campaign is the New Zealand anti-stigma campaign, "Like Minds, Like Mine." The campaign's website explains that "the name "Like Minds, Like Mine" plays on the phrase that 'we are all of like mind.'" The website goes on to say that some ways of understanding the name include that "mental illness can happen to anyone," "look at similarities rather than differences," and "we are all similar." This demonstrates the move towards a normalization approach. The Mental Health Commission of Canada's *Opening Minds* initiative has already launched a series of commercials portraying individuals "just like us" who have been diagnosed with a mental illness.

Also, borrowing a bit from the information, media and social attitudes approach, one of the first tasks of the Mental Health Commission of Canada's anti-stigma initiative was holding a symposium on March 19, 2010 for journalism and community services students titled, "Stigma: Mental Illness, Misconceptions and Stereotypes." As discussed above, it can be difficult to change mainstream media, as power often exerts large-scale systems of thought and discourse, and as Smith maintains, mainstream media often, "follows rather than leads social norms" (2002). The challenge will be that many of the journalism students attending such a symposium will have to return to work for editors and media corporations and may find it difficult to write articles that challenge larger perceptions of mental illness and/or addiction. And yet, there are independent media that continue to

question modes of functioning of power, as well as organizations such as the Media Awareness Network that strive to arm youth with media literacy skills in order to challenge the prevailing discourse.

Chapter 3 The Pathologization of Human Difference

At the heart of the normalization approach employed by the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative is the concept that people diagnosed with a mental illness and labelled as "mentally ill" are "just like us." Yet the models which people use to define mental illness (also discussed in Chapter 2) are, for the most part, based upon social norms. People who do not conform to these norms of behaviour as they are laid out by society are labelled as "mentally ill." Social norms are defined as that which establish "yardsticks for behaviour that are functional in terms of supporting the hierarchy and ensuring the coherence of the organization" (Oliver, 2010, p. 57). The upper levels of the hierarchy determine the norms that are to regulate the conduct of the people within the organization (Oliver, 2010).

Michel Foucault argued that the institutionalization of individuals diagnosed with a mental illness is a way of policing the public and ridding society of human difference (1977). In this chapter I discuss the pathologization of human difference, particularly when it refers to reinforcing, restraining and policing heterosexual gender norms. As discussed in Chapter 1, Judith Butler argues that gender is unstable, it is something we "do" rather than something we "are" (1999, p. 25). She argues that through repetitive acts, gender "congeals" in such a way that appears as though it has been there all along (1993, p. 9). But, Butler writes, there is nothing "natural" about the category of gender at all, gender is a discursive construct that is constrained by the power structures in which it is located (1999, p. 189).

In this chapter I look at how certain identities that do not fit neatly into the prescribed categories of "girl" and "boy," "woman" and "man," "female" and "male," such as gender variant or transgender identities, are pathologized. Transgender is a term applied to a myriad of individuals, behaviours and groups with regard to tendencies to differ or vary from culturally-conventional gender roles. It is when the state of one's gender identity (i.e. self-identification as man, woman, neither or both) does not match one's assigned sex (i.e. identification or assumptions by others as male, female or intersex based on physical sex) (Gay and Lesbian Alliance Against Defamation, 2010). The term "transgender" is not associated with any specific form of sexual orientation. People who identify as transgender may identify as heterosexual, homosexual, bisexual, pansexual, polysexual or asexual. Some people who identify as transgender may consider conventional sexual orientation labels as inadequate or not applicable to their circumstances or vision of self (Layton, 1996).

People who identify as transgender may have characteristics that are usually associated with a particular gender, or that are placed elsewhere on the traditional gender continuum or may exist outside of the traditional gender continuum, as "agender," "genderqueer," or "third gender." Transgender people may also identify as bigender or existing along several places on the traditional transgender continuum.

Though it may not be apparent at first, the pathologization of natural human diversity has large implications with regard to anti-stigma campaigns in Canada because in the process of pathologizing natural aspects of human diversity, certain identities have become even further stigmatized. An example of this is the inclusion of gender-variant

identities in the Diagnostic and Statistical Manual of Mental Disorders under the label of 'Gender Identity Disorder.'

Instead of trying to ascertain whether a transgender individual seeking sex-reassignment surgery is mentally healthy and stable, and prepared for such a surgery and its subsequent adaptations, a transgender individual seeking sex-reassignment surgery must present as mentally ill to have the surgery. In labelling individuals who identify as transgender with a mental disorder, these identities are then further stigmatized.

3.1 The Diagnostic and Statistical Manual of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders is seen as *the* authoritative manual of psychiatric classifications in North America. First published by the American Psychiatric Association in 1952, it has continually evolved and been revised over the years. One can learn a lot about the history of mental illness by looking through the numerous editions of this manual. One may notice for instance that throughout the twentieth century, psychiatrists divided mental disorders into two main classes: *organic illnesses* which have an obvious cause such as intoxication or a brain lesion which causes dementia, and *functional illnesses* which have no ascertainable biological cause (Lindqvist & Malmgren, 1993). Toward the end of the twentieth century, the division between organic and functional disorders began to be criticized, many psychiatrists arguing that all psychiatric illness is biological. In 1994, the distinction between organic and functional disorders was entirely removed from the Diagnostic and Statistical Manual

of Mental Disorders, with those disorders known as organic appearing under the domain of neurology. Psychiatry continues to be preoccupied with disorders that fall under the category of "functional." Under functional disorders, there is a subdivision between psychotic disorders and nonpsychotic disorders (then further divided into specific diagnoses).

The first Diagnostic and Statistical Manual of Mental Disorders was published in 1952 and was heavily influenced by psychoanalytic theory with an emphasis on individual failures of adaptation to biological or psychosocial stresses as the cause of psychiatric illness. The first edition contained 106 diagnoses and was 130 pages long. This first manual increased the number of diagnoses of ways in which nonpsychotic illnesses could be experienced and named. It was said that this change in the number of different diagnoses redrew the line between "dis-eased" and "normal" distress, resulting in the creation of entirely new patients (Science Encyclopedia, 2010).

The great increase in the number of psychiatric diagnoses was said to be due to two interrelated phenomena; 1) the psychiatric professions' response to World War II; and, 2) the increasing authority of psychoanalytic theory and practice. World War II was said to have strengthened the belief "that environmental stress contributed to mental maladjustment and that purposeful human interventions could alter psychological outcomes" (Grob, 1991, p. 427). The rise of psychiatrists following psychodynamic beliefs (successfully treating those returning from the war with psychosocial interventions strengthened many psychiatrists' convictions in psychodynamic tenets), was reflected in the second edition of the Diagnostic and Statistical Manual of Mental

Disorders published in 1968. Like the first edition, this one presented a psychosocial view of psychiatric illness. The psychosocial view was that:

> *...psychiatric illnesses were reactions to everyday living, not discrete disease entities that could easily be demarcated from one another or even from normal behavior or experience. From this perspective, naming a disease was of much less consequence than understanding psychic conflicts and reactions that gave rise to symptoms.*
>
> *(Science Encyclopedia, Psychology and Psychiatry – Diagnosis, 2010)*

The second edition contained 182 diagnoses and was 134 pages long.

After the 1970s, things began to change, "understanding psychic conflicts and reactions" that give "rise to symptoms" became less important and diagnoses became central. In 1974, Dr. Robert Spitzer was put in charge of the third edition of the Diagnostic and Statistical Manual of Mental Disorders.

> *By then, psychiatry itself was in crisis: Doctors seeing the same patients agreed on a diagnosis only 20 per cent of the time. With Freud's notion of the unconscious conflict as the seed of mental illness under heavy attack, Dr. Spitzer set out to create a more concrete diagnostic system, relying entirely on symptoms doctors could see with their own eyes...Dr. Spitzer and 15 hand-picked, data-oriented researchers then carved human mental affliction into 265 disorders — frequently with no more compelling scientific evidence to back them up than their own judgment....He also....created checklists of symptoms for each disorder. Specific mental illnesses were now categorized and "measurable."*
>
> *(Brown, July 9, 2011)*

The presence of the third, fourth and the current edition of the Diagnostic and Statistical Manual of Mental Disorders, with their distinct illness categories that delineate what is

considered "normal" and what is considered "abnormal" (Wilson, 1993), demonstrates American psychiatry's shift towards a biomedical model of disease. In its third edition, published in 1980, the manual's number of diagnoses increased by 146 per cent with 265 classifications, and grew to 494 pages. The revised third edition, published in 1987 grew to 292 diagnoses and 567 pages. The latest edition of the manual, published in 1994, contains 297 diagnoses and is 886 pages.

The fifth edition is currently in the consultation, planning and preparation phase — preliminary draft revisions are available for public review — and will be published in May 2013. This edition has become the most controversial of them all. It has been reported that the rough draft published on the American Psychiatric Association's website has generated over 50 million hits and more than 3,000 signed comments so far (Brown, July 9, 2011). The proposed new edition has a myriad of new categories of diagnosis including "premenstrual dysphoric syndrome," defined as the "marked lability of mood interspersed with frequent tearfulness…subjective feeling of being overwhelmed or out of control." It also has widened the definitions of many diagnoses. For example, the diagnosis of "obsessive compulsive disorder" is now a category and includes individuals previously diagnosed with "body dysmorphic disorder" defined as a "preoccupation with a defect in appearance," as well as individuals diagnosed with "trichotillomania" otherwise known as "hair pulling."

There were many mental health disorders that came into existence for the first time in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, and unlike the previous editions, the intention of the manual was to guide in psychiatrists'

assessments and diagnosis of patients. Instead of being based on clinical expertise, in the third edition there was a heavy reliance on standardized and statistical knowledge based on groups rather than on individuals. This edition took on the reductionist view of disease where biology became paramount. Psychoanalytic theory was traded in for biopsychiatry that "largely rejected a disease model rooted in individual biographies, psychological conflict, and psychosocial stressors" (Science Encyclopedia, Psychology and Psychiatry – Diagnosis, 2010).

A clear assumption lies beneath the third edition of the Diagnostic and Statistical Manual of Mental Disorders – that biology is the primary cause of mental disorder and not psychological conflict. A strong example of this assumption is demonstrated in the removal of the word "reaction" from the third edition of the manual. An individual who would have been previously diagnosed as having "psychotic depressive reaction" was now diagnosed with "major depression with psychotic features." Because diagnoses are rooted in biology, they were seen as made up of an exclusive and determinant set of symptoms. The earlier psychodynamic view of disease espoused that a given set of symptoms depended on the individual's life history and beliefs and could be the result of any number of underlying psychological conflicts. Of note, this shift occurred with the increase of pharmacological treatments of psychiatric diseases. Also of interest is that problems formerly seen as expected parts of everyday life, that then became defined as psychiatric illnesses by virtue of their psychosocial etiology, now became viewed in the twentieth century as "disorders," subject to purely biological interpretations and treatments.

The current edition (the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders – text revised) being used in North America is more than 900 pages long, listing 365 disorders and set to sell over one million copies (Brown, July 9, 2011). In the United States, insurance companies will only reimburse prescription medications on health plans if the diagnosis is based on the Diagnostic and Statistical Manual of Mental Disorders (Brown, July 9, 2011) and courts both in Canada and the United States use the Diagnostic and Statistical Manual of Mental Disorder in order to define insanity. With each new edition of the manual, pharmaceutical companies have seen larger and larger profits, as diagnosis means treatment and treatment, means medication.

> *Dr. Frances notes that health-insurance companies typically favour DSM [Diagnostic and Statistical Manual of Mental Disorders]-driven medications over talk therapy because the former is cheaper in the short run. But in the longer term, he says, disorders such as depression are more cheaply and just as effectively treated with talk therapy, given the potential consequences of so many people taking so many serious drugs. Freud's system, the resolution of unconscious conflicts that cause mild anxieties and neuroses, might live to cure another day.*
>
> *(Brown, July 9, 2011)*

Brown writes that it becomes impossible to ignore the relationship between the pharmaceutical industry and the over-diagnosis and off-label prescribing which the Diagnostic and Statistical Manual of Mental Disorders helps to facilitate (July 9, 2011). He writes that the bestselling drugs in the United States nowadays are antipsychotics, "a serious class of psychoactive medication now being given to more than half a million children" (July 9, 2011, p. 3). This medication makes up five per cent of all prescriptions (totalling $14 billion a year), and though originally used for severe forms of

schizophrenia is now being used for bipolar disorder, as well as in elderly patients in nursing homes when perceived as agitated (though the medication greatly impacts life expectancy) and for children who misbehave (Brown, July 9, 2011).

There are a myriad more criticisms of the Diagnostic and Statistical Manual of Mental Disorders, including that it is over-inclusive. Other criticisms include that the classifications are quite arbitrary, that the diagnoses are imprecise, that the manual itself lacks reliability and validity, and that the manual contributes to the pathologization of normal human diversity (Lev, 2005; Brown, 1994; Caplan, 1995; Kirk & Kutchins, 1997; Szasz, 1970; Wakefield, 1997). Another criticism is that the approach to diagnosis in the manual's third and fourth edition requires the presence of a minimum amount of symptoms from a list that either denotes the presence or absence of a disorder.

Mental illness or mental disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders as "a manifestation of a behavioural, psychological, or biological dysfunction in the individual" (2000, p. xxxi). It also says that, "Neither deviant behaviour (e.g. political, religious or sexual) nor conflicts between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual," (2000, p.xxxi). Arlene Istar Lev writes in "Disordering Gender Identity," that the consequence of this ambiguity on "individuals who express 'deviant' political, religious, and especially sexual lifestyles has been under-examined" (2005, p.37).

3.2 Gender Identity Disorder

Lev writes that the controversy over the inclusion of Gender Identity Disorder and Transvestic Fetishism in the Diagnostic and Statistical Manual of Mental Disorders raises two challenging and compelling questions. The first question concerns the use of psychiatric classifications to label individuals with sexual behaviours and gender expressions that are different from the norm as mentally ill. The second question is about the "ethics of using a psychiatric diagnoses within a manual of mental illness to provide legitimacy for transsexuals' right to attain necessary medical treatments" (2005, p. 37), meaning the requirement for individuals who identify as transgender and who want to access sex-reassignment surgery to first be diagnosed with a mental illness.

As Hinshaw wrote in *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change (2007)*, diagnostic classification systems are supposed to be based on objective, unbiased, scientific evidence. Yet Foucault observes in *Madness and Civilization: A History of Insanity in the Age of Reason (1971)*, that if one looks at the history of diagnostic classifications in western culture, one can find bias and prejudicial assumptions at every turn, and find that underneath the statistics and "science" lies the construction of social norms, and the intentional attempt to seek out those whose behaviours deviate from "the norm." Foucault defines this as institutionalized social control. Lev writes:

> *The psychiatric field has a long history of using diagnostic classifications to pathologize ordinary human diversity in the realms of race, ethnicity, sex, gender, class, disability, and sexual orientation, and being labelled psychologically*

> *deviant has inevitable consequences for the civil rights and social status of minority peoples.*
>
> *(2005, p. 38)*

Lev notes that throughout the years, racism, sexism and homophobia have been "dressed up as science" influencing clinical assessment and public policy in extreme ways (2005, p. 41).

Racism

In the 1800s, scientific medical experts wrote that immigrants to the United States, mainly those from Ireland, were predisposed to mental disorders, criminality and other forms of social deviance (Lev, 2005). Also during this time, two common disorders were drapetomania (defined as a mental disorder among African slaves, the primary symptoms being attempting to escape slavery) and dysathesia ethiopica, (defined as a mental disorder among African slaves, the primary symptoms being the destruction of plantation property, disobedience, refusal to work and fighting with their masters) (Kirk & Kutchins, 1996). These types of diagnoses were used to support such things as the need for slavery and racial segregation, as well as the implementation of strict quotas on the immigration of various European and Asian groups (Kirk & Kutchins, 1996).

Sexism

Medical diagnoses also reinforce sexist policies, with women being labelled with an array of mental disorders over the years, including neurasthenia (with symptoms of weakness, dizziness and fatigue that required a "rest cure") nervous prostration (an

emotional disorder that entails exhaustion and the inability to work), dyspepsia (one of the symptoms being indigestion), and hysteria, which were all associated with the "wandering uterus" travelling throughout the woman's body, and strangling the woman as it reaches her chest, causing hysteria of sorts (Ehrenreich & English, 2005). Geller and Harris write in *Women of the Asylum: Voices From Behind the Walls 1840-1945 (1995)*, that women were subject to institutionalization, clitoridectomies (the surgical removal of the clitoris), hysterectomies (the surgical removal of part or all of the uterus), leeches placed on their labias, removal of ovaries and confined rest cures based on diagnoses such as those above (1994). Katz writes in *The Invention of Heterosexuality*, that when women were seeking the vote, they were said to be suffering from a mental disorder known as andromania, which is defined as an excessive or obsessive preoccupation with or fondness of men (2007).

Lev writes that an example of sexism that still exists today is how the impact of traumas such as childhood sexual abuse, adult sexual assault, and domestic violence on women is being overlooked and symptoms derived from such trauma are being used to mis-diagnose mental disorders such as Dissociative Identity Disorder or Borderline Personality Disorder (2005). Caplan writes in *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal* (1996) that another example of sexism in psychiatry is the diagnosis of Premenstrual Dysphoric Disorder (the symptoms of which include severe premenstrual syndrome, PMS), being proposed in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.

The violence of such pathologization and categorization of the lived experiences of women and the multiple traumas which women may have experienced can have a myriad of effects. The melancholia associated with the violence of such diagnoses can remain imprinted upon the bodies of women, introjected in a way that we become such loss.

Homophobia

Psychiatry also has a long history with homophobia, with homosexuality being labelled as a "sociopathic personality disturbance" in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (1952), and labelled as a "perversion" in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (1968) (Lev, 2006, p. 40). Up until the 1970s, it was assumed that all people who identified as homosexual suffered from psychopathology (Smith, 1988). In 1973, homosexuality was removed from the second edition of the Diagnostic and Statistical Manual of Mental Disorders because "it failed to meet the criteria for distress, disability and inherent disadvantage" (Lev, 2005, p. 40). But Lev points out that homosexuality was not "technically removed" but rather modified. The diagnosis of Ego-Dsytonic Homosexuality appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, and was defined as "the subjective experience of unhappiness and contrasted with syntonic behaviour or one's comfort with their same-sex desires" (2005, p. 40). This diagnosis was then modified in the revised version of the third edition of the Diagnostic and Statistical Manual of Mental Disorders, but in the fourth edition, under

Sexual Disorders Not Otherwise Specified, one of the definitions includes "Persistent and marked distress about sexual orientation" (American Psychiatric Association, 2000, p. 582). Lev points out that is "presumably not commonly used to treat heterosexuals who are unhappy with their sexual orientation" (2005, p. 41).

Whittle's article, "The history of a psychiatric diagnostic category: Transexualism," says that the year that homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders, Gender Dysphoria Syndrome was added (1993, p.30). Lev asserts that this diagnosis has been "continually used to pathologize lesbian, gay and bisexual people, and particularly youth" (2005, p. 41). This demonstrates our continual need to police not only heterosexual gender categories but desiring bodies in order to conceal the fluidity of gender and sexuality.

Gender Identity Disorder

Through some of the above examples, one can see how clinical diagnoses have been used in ways to pathologize and as Lev writes "(mis)label the ego-dystonic pain minorities experience, as well as their attempts to stand up to oppressive policies" (2005, p. 41). The same case can be made for the pathologization of transgender people. The diagnosis of Gender Identity Disorder is simply an attempt to reinforce social norms and police the constructed boundaries proscribed to sexed bodies and gender expressions. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders defines Gender Identity Disorder in adolescents and adults as:

> A. *A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of*

being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. *Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g. request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.*

C. *The disturbance is not concurrent with a physical intersex condition.*

D. *The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

(1994, p. 302.85).

This psychiatric diagnosis tries to define what are very complex issues involving gender identity, sexual desire, emotional distress and trauma, and not conforming to social norms. This attempt to further try to label and categorize gender variant identities can easily be viewed as a method of social control, as it tries to further stigmatize and alienate individuals who may not fit neatly into the socially-constructed categories of gender and sex by claiming such gender expressions are dysfunctional and therefore, a mental disorder or illness. Any form of diversity is pathologized in order to conceal the fact that gender and sex categories may not be as stable as perceived, any form of diversity is pathologized. In short, any identity that is a reminder of the fluidity of such categories is pathologized. Lev writes,

> *In Western cultures...sexed bodies and gender expressions are severely proscribed, assigned, and delineated and deviations from these norms are classified within the sphere of the medical and psychiatric establishments.*
>
> *(Lev, 2005, p. 42)*

3.3 The Production of Identities That are Prohibited

Power structures often produce identities that they then prohibit (this will also be discussed in Chapter 4). In the creation of Gender Identity Disorder, and the linking of this diagnosis with the ability of transgender individuals to access necessary medical surgeries, the medical and psychiatric establishment have forced a very rigid definition of transgender identity (an identity that is already stigmatized within society). And by linking such an identity to a mental disorder, they have further stigmatized people who identify as transgender. Lev writes that diagnoses related to gender issues are based on "classification systems that seek to type and subtype gender variant people in order to determine who is "really" transsexual and only those who fit certain narrow criteria are deemed eligible for further medical treatments" (2005, p. 43). Society has already created very strict gender and sex categories and individuals who do not fit these rigid categories are stigmatized in an attempt to continually reassert and police the boundaries of such terms. Gender variant people are perhaps a reminder that "male" and "female," "woman" and "man," are socially-constructed binary terms. In order to keep up the appearance that these constructs are "natural," the medical and psychiatric establishments need to pathologize such identities.

The creation of Gender Identity Disorder is a perfect example of Foucault's theory of psychiatry being used as social control — in creating a very strict and rigid definition of transgender, individuals seeking sex-reassignment surgery are forced to take up at the same time both the proscribed transgender identity and the identity of someone living with a mental illness. In this way, individuals who seek sex-reassignment surgery are forced to tell their histories, their stories, in a way that will conform to the proscribed definition of transgender identity. The authority of the medical and psychiatric establishments 'hail' an individual to such an identity, but the individual must be willing to accept the proscribed definition of such an identity. There will be some gender variant people who do not fit the definition laid out in the Diagnostic and Statistical Manual of Mental Disorders and will therefore, be forced to conform in order to get the desired surgery.

The Production of Desire

Power structures may also work to produce a proscribed desiring body as well. Dallas Denny writes in "*The politics of diagnosis and a diagnosis of politics: The university-affiliated gender clinics*," (1992), that having what researchers deemed as the "correct" sexual orientation became a factor in the eligibility for sex-reassignment surgery (p.12). In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, questions to pose in the diagnosis of Gender Identity Disorder include asking the individual about their sexual orientation. Yet it has been documented that gender-variant people express a diversity of sexual orientations that may exist outside the

traditional nomenclature (Denny, 1992). This means that transgender individuals who express sexual orientations that are not deemed "correct" may not be diagnosed with gender identity disorder, which in turn means a denial of access to sex-reassignment surgery. Some individuals seeking sex-reassignment surgery may be forced to change their narrative with regard to sexual orientation to fit the proscribed definition of "transgender" laid out by the Diagnostic and Statistical Manual of Mental Disorders.

The Fluidity of Gender

Over the past two decades, as Richard Ekins and Dave King write in "Blending genders: Contributions to the emerging field of transgender studies," (1998), there has been an increase in transgender individuals who identify themselves as bigendered, mixed gendered, dual gendered, gender-blended, or gender-queer, and may seek surgery to accentuate certain masculine or feminine characteristics without the desire to have complete sex-reassignment surgery. Kate Bornstein writes in *Gender Outlaws: On Men, Women, and the Rest of Us,* (1994), that some individuals see their gender as fluid, some individuals see their gender as ever-changing throughout their lifetime, or even just throughout one day, and some individuals see their gender as resting somewhere in the middle (1994). This means that it is impossible to restrict gender to two binary categories.

Gender Dysphoria vs. Healthy Transgender Individuals

The diagnostic criteria of Gender Identity Disorder conflate individuals who are truly suffering from gender dysphoria with individuals who desire sex-reassignment surgery (Lev, 2005). The diagnosis negates the fact that there are many happy, healthy, functional transgender people who desire sex-reassignment surgery (Lev, 2005). Therefore, the underlying message is that individuals who seek sex-reassignment surgery must be abnormal, dysfunctional, and suffering from a mental illness. Lev writes,

> *...if gender-variant experience was not originally pathologized, perhaps people would experience far less social and occupational difficulties. The distinctions between distress that is within human beings and that which is externally imposed is not clearly delineated in this section [Gender Identity Disorder section of the DSM-IV]...Granted the line between social injustice and individual pathology can be difficult to discern, since the stigma of cross-dressing and gender transitions can interfere with marital relations, as well as occupational stability, and in certain locales may have legal ramifications. However these are consequences of gender oppression, not inherent to having a cross-gendered identity.*
>
> *(Lev, 2005, p.48)*

This means that distress may not be caused by having a non-conforming gender expression, but rather the social implications in actualizing them. If gender-variant behaviour was not pathologized and subsequently stigmatized because these expressions are labelled as a mental illness, than it is suggested that transgender and transsexual individuals might experience a significant reduction in emotional, legal and social distress (Lev, 2005).

Another criticism of the diagnostic classification of Gender Identity Disorder is that it does not capture the true distress and dysphoria some gender variant people experience (Lev, 2005). The list of symptoms implies that distress and emotional impairment relate to the transgender identity and not to the extreme stigmatizing attitudes of society towards those who identify as transgender.

Another criticism of the psychiatric classification of Gender Identity Disorder is that it is oftentimes used to diagnose children and youth exhibiting cross-gender behaviour, who are then treated to prevent both adult homosexuality and transsexualism. This demonstrates how a Diagnostic and Statistical Manual for Mental Disorder classification may be used as a tool of social control or a method of "policing."

3.4 Mental Illness, Stigma and its Association With Heterosexual Gender Norms

Lev writes that the criteria of Gender Identity Disorder are based on "stereotypical sexist and heterosexist assumptions regarding normative male and female experience, as serves to reify a traditional gender-based hegemony" (Lev, 2005, p. 42). When looking at the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Illness, one can see that in reference to "gender" there are very rigid definitions of "girl" and "boy," "woman" and "man," and therefore, any individual who expresses gender in a different way may be perceived as having a mental illness.

In this chapter, I have looked at the association between the diagnosing and labelling of mental illness and the production, restraining and policing of heterosexual gender norms. The example of Gender Identity Disorder demonstrates how an already

stigmatized group is further stigmatized when labelled as mentally ill. Anti-stigma initiatives that work to combat stigma against individuals who are diagnosed with a mental illness and labelled as mentally ill must begin to look at who and what groups are being labelled, and why. In avoiding the actual labelling process involved when an individual is diagnosed with a mental illness and the consequences of such labelling, anti-stigma campaigns can only be very narrowly effective. In simply concentrating on how individuals such as professionals and youths (the two groups presently being targeted by the Mental Health Commission of Canada's anti-stigma campaign, *Opening Minds*), need to change their stigmatizing attitudes towards individuals diagnosed with a mental illness, there is an avoidance of a much larger discussion about the construction and definition of mental illness itself. Also about how individuals whose sexual behaviours or gender expressions differ from the "norm" are actually further stigmatized by being labelled as having a mental illness.

The type of stigma experienced by transgender individuals who are labelled as having Gender Identity Disorder is wide-ranging and requires consideration in anti-stigma initiatives. As discussed above, individuals labelled with Gender Identity Disorder are oftentimes forced to change their stories and their histories to meet the very narrow definition of "transgender" defined in the Diagnostic and Statistical Manual of Mental Disorders. This forced conformity can be considered a violent act, as individuals tell their stories in ways that conform to the psychiatric institution's definition of "transgender." The resulting trauma can have a large impact on an individual's health and well-being.

These types of impacts flowing from the stigmatization process must also be addressed by anti-stigma initiatives.

In the example of the pathologization of natural human diversity when concerning gender expressions and sexed bodies, and the subsequent double stigmatization this entails, there is definitely a necessity to examine the complexities of stigma and mental illness and addiction further than a sex- and gender-based analysis would allow. The Mental Health Commission of Canada must begin to examine the process of labelling with regard to mental illness, and its association with the restraining and policing of heterosexual gender norms.

Of the 25 organizations chosen by the Mental Health Commission of Canada to conduct research projects on stigma and mental illness and addiction in the first year of the creation of the *Opening Minds* initiative, not one organization dealt with gender variance. In fact, with one of the main target groups of the anti-stigma initiative being youth, there is not one project focused on lesbian, gay, bisexual, transgender and queer (LGBTQ) youth, of the stigma experienced by this group, and the consequences of stigmatizing attitudes on LGBTQ youth's mental health.

As far as the Diagnostic and Statistical Manual of Mental Disorders, the new revisions suggested by the American Psychological Association's committee in charge of revising the manual includes changing the diagnosis of Gender Identity Disorder to Gender Incongruence. This means that gender variance will still be classified as a mental illness in the forthcoming edition.

Chapter 4 Women, Addictions and Stigma

In this chapter I will be looking at the stigma associated with women who are struggling with addictions issues. In the first half of this chapter, I explore how addictions issues are often responses to the powerlessness incurred by gendered violence and the instability of gender categories, and how the stigma associated with women who struggle with addictions issues uses this very same powerlessness and trauma against them. The bodies of women with substance-use problems become the site of double the violence, trauma and aggression. Within this analysis, I also look at how power structures work to produce this stigmatized identity in order to police and restrain heterosexual gender norms, and conceal the instability of gender categories. In the second half of this chapter, I more specifically consider the stigma associated with pregnant and mothering women with substance-use issues, and how media, law and health care institutions help to produce and police the very tight confines of gender categories, in particular the dichotomy between "good mothers" and "bad mothers." At the end of this chapter, I review some examples of how women have resisted the label of addict, and possible alternatives for women in taking up the identity of "addict."

4.1 Addictions and Stigma in Canada

According to Statistics Canada, 1 in 10 Canadians (around 2.6 million people) 15 years of age and over report symptoms consistent with an alcohol or illicit drug dependence (2003). The Centre for Addiction and Mental Health reports that substance-

use problems affect Canadians of all ages, education levels, income levels, religions, cultures and workforces. Today, it is likely that every Canadian knows at least one friend, family member or co-worker who has struggled with a substance-use problem at some point in their lives.

For people living with substance-use problems, the struggle with addictions is often coupled with a secondary fight against the negative attitudes and behaviours often levelled at individuals labelled as addicts. The stigma experienced by individuals living with a substance dependency can be debilitating and can affect a myriad of determinants of health including access to appropriate housing and employment, and the ability to forge healthy relationships with others.

The concept of responsibility plays a major role in the stigma experienced by people living with addictions issues. Unlike mental illness, individuals living with a substance-dependency are oftentimes portrayed as or perceived as solely responsible for their own predicament, as lacking the "willpower" to stop. In a 2008 health survey done by the Canadian Medical Association, it was reported that 50 per cent of Canadians think that alcoholism and drug addiction are not mental illnesses. People who have never experienced a problem with substance use negatively perceive individuals living with addictions as weak, and deficient in the moral fortitude or the strength to overcome their desire for alcohol or other illicit substances.

But when it comes to addictions issues, the concept of "response-ability" might be closer to the truth. Research has documented strong associations between addictions and trauma (as will be discussed further on in this chapter). We must begin to acknowledge

that some people may choose to respond to various traumatic experiences, including childhood sexual violence, domestic violence, racism, poverty, sexism, and homophobia by way of addictions as a coping strategy. It is our responsibility, as a community, and as a society, to offer alternative ways for an individual to respond to trauma. Whether it be on an institutional level, providing affordable housing options, higher minimum wages, mechanisms to report discrimination, support groups to help work through experiences of violence, or mental health care and addictions services that acknowledge the impact of trauma. Whether it be on an individual level, by arming ourselves with the proper ways to respond to an individual who is in crisis, who may need assistance, and who may want to disclose and share their stories. By offering alternative ways to respond to trauma, and by empowering individuals with the skills and abilities to respond differently, we may begin to create real spaces for recovery and healing.

The problem lies in the fact that stigma against individuals living with substance-use issues is entrenched in moral beliefs (i.e. people oftentimes use the moral model discussed in Chapter 2 to define addiction issues). Hence the often referenced terms "lack of willpower" are used by people who hold stigmatizing beliefs about individuals living with substance-use problems. Hinshaw writes that stigma associated with the moral model is often the hardest to combat (2007). Unfortunately, research has shown that when an individual is held responsible for her/his stigmatized condition, s/he is apt "to be treated negatively and to be viewed unfavourably" (Jones et al., 1984, p.58). The spreading of negative stereotypes about people living with addictions has been likened to

a "contagion," quickly spreading from person to person until it infects whole communities (Kallen, 1989).

4.2 Why Gender Matters When Discussing Addictions

The World Health Organization has reported that the lifetime prevalence rate for alcohol dependence is more than twice as high in men than women (2011). The World Health Organization found that in developed countries, approximately one in five men and one in twelve women will develop an alcohol dependency during their lifetime (2011). But when it comes to accessing appropriate addictions treatment services, the World Health Organization found that men are more likely than women to disclose problems with alcohol use to their health care provider (2011). This finding is on par with other studies done in Canada that denoted a far greater reluctance for women to seek treatment for substance-use problems (Weisner & Schmidt, 1992; Copeland, 1997). In fact, recent North American studies have found that the gap between men and women's substance use, particularly problem drinking, is closing with a growing number of younger women reporting problems with alcohol use. In a 2009 study published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, it was found that in a 30-year period binge drinking (which is defined as having five or more drinks on one occasion) in young men has experienced a decline, with a 50 per cent decline in boys 15 to 17 years of age, a 20 per cent decline in young men 18 to 20 years of age and a 10 per cent decline in young men 21 to 23 years of age (Grucza, Norbert, & Bierut, 2009). Yet

in young women the opposite was found. While binge drinking in women 15 to 20 years of age has remained statistically unchanged, there has been a 40 per cent increase in binge drinking in women 21 to 23 years of age (Grucza, Norbert, & Bierut, 2009). And yet, despite the dramatic rise in problem alcohol use in young women, which is closing the gender gap in addictions, the ratio of men to women in addictions treatment centres remains the same at a ratio of four to one (Copeland, 1997).

When it comes to accessing appropriate addictions treatment, women face a myriad of barriers including financial limitations, the inaccessibility of child care, and a lack of services tailored to the specific needs of women (Weisner & Schmidt, 1992). Beyond these obstacles, research has demonstrated that stigma plays a very large and concerning role when it comes to barriers to women in accessing appropriate treatment and care (Weisner & Schmidt, 1992). The stigma associated with addiction differs for men and women and, I would argue, is based upon heterosexual gender norms.

Historically, women struggling with alcohol or illicit drug dependence have been perceived as "sexually promiscuous." Sheila Blume writes in *Sexuality and Stigma: The Alcoholic Woman*, that this stereotype differs from that associated with the alcoholic or drug-addicted man, who is often perceived as a "skid row derelict," because it is enclosed with a culturally-ingrained expectation of hypersexuality and sexual promiscuity (1991, p. 142). This negative stereotype has often been linked to the different drinking standards for men and women proscribed in societies that allow for the consumption of alcohol. It has been argued that beneath the different recommendations on the amount of alcohol that can be safely consumed by men and women, which is based on the differing effects

of alcohol on the two sexes, lies the deeply entrenched cultural belief that alcohol use in women leads to the undoing of morals within society (Sandmaier, 1980). Blume demonstrates how throughout history, differing drinking standards have been deeply rooted in culturally-ingrained beliefs that women's alcohol use leads to sexual promiscuity and a loosening of morals. For example, in the Talmud it is written, "One cup of wine is good for a woman; Two are degrading; Three induce her to act like an immoral woman; And four cause her to lose all self-respect and sense of shame," (Gomberg, 1986, p. 82). The German philosopher Immanuel Kant wrote in 1798 that women avoid drinking because they adhere to a higher moral code and that "intoxication, which deprives one of cautiousness, would be a scandal for them" (Jellinek, 1941, p. 777). Blume explains how Kant's writing demonstrates how women have been placed on "a pedestal," and how a woman who struggles with a substance dependency can experience a perceived "fall from grace" (Blume, 1991, p. 144).

The association between addictions and sexual promiscuity in women causes what Jan Copeland (1997) describes as a "double deviance." This refers to the extremely negative stereotype that in addition to being addicted, women with substance-use problems are also being perceived as "sluts," "whores," or "loose." In Copeland's research, she found that when women were asked who was looked down upon more, men or women, with regard to alcohol and illicit drug problems, 78 per cent of women felt that women were more looked down upon. Female participants felt that women were already treated with less respect and looked down upon and so if they were struggling with a problem that is perceived as lacking moral and social restraint combined with overtones

of sexual promiscuity and poor maternal instincts (which will be discussed later on in this chapter), they were twice as likely to be treated with disrespect (Copeland, 1997, p. 182). This perceived double deviancy creates massive barriers to appropriate addictions treatment for women living with a substance dependency. It can create a conflation whereby women living with addictions feel that if they take up the label of "addict," they are also forced to take up the label of "slut," "whore," and "loose."

Race and class further compound the stigma experienced by women struggling with addictions issues. As research has demonstrated, membership in socially marginalized groups creates a doubling of stigma, with substance use being portrayed as "more deviant" (Clinard & Meir, 1992). An example of this would be the treatment of Aboriginal women in Canada who use substances.

> *Aboriginal women are strongly affected by the pervasive, negative attitudes of society toward women who abuse substances. Public attention has often been brought to bear specifically on Aboriginal women who abuse substances...The stigma experienced by Aboriginal women, as well as the punitive actions taken against them, create significant barriers to accessing treatment and support they need and deserve.*
>
> *(Women's Health Bureau, 2001)*

The intersections of race and class, and the multi-layered structure of stigma, create what might be seen as a "triple deviancy" or "quadruple deviancy," that require thoughtful consideration in any anti-stigma campaign working to combat the stigma levelled at women with substance-dependency issues.

Trauma: Addictions as Responses to Powerlessness

What makes the stigma associated with women who struggle with addictions even more despairing is that, statistically, women living with addictions are more likely than women without substance-use problems to have experienced sexual abuse as children. The estimates of the prevalence of incest vary from 12 per cent to 85 per cent of alcoholic women, depending on the populations studied (Beckman & Ackerman, 1995). For women survivors of child sexual abuse, the use of alcohol and/or drugs may have started at a young age as a way to cope with the trauma. Research from the Cedar Project Partnership (comprising of the Prince George Friendship Centre, Carrier Sekani Family Services, Northern Health Authority, Positive Living North, the Red Road Aboriginal HIV/AIDS Network, Central Interior Native Health and Vancouver Native Health Society) which investigated the intersections of trauma, substance use and HIV vulnerability among Aboriginal girls and young women found the following:

> *At baseline, 512 young people who used substances enrolled in Cedar, of whom 262 were girls or young women...the histories of the female participants are very disturbing. Most (65 per cent) were already using injection drugs at the time of their first visit. The large majority (68 per cent) had experienced early childhood sexual trauma, with the mean age of their first abuse reported as seven years. Many of the girls and young women (68 per cent) had been in foster care, with the mean age of their first removal from their families reported as five years.....The girls and young women in the project first started smoking illegal substances at a mean age of 16 years, and began injecting drugs at a mean age of 17 years. Over half of those who smoked drugs (58 per cent) reported having exchanged sex for money, drugs or shelter, on average at 16.8 years old, while over three quarters (78 per cent) of*

> *those who used injection drugs reported having exchanged sex, with a mean initiate age of 16.5 years. Girls and young women who used injection drugs were significantly more likely to have spent time in the prison system (67 per cent [versus 36 per cent] had been in prison more than two nights), with a mean age of first entering corrections of 17 years. The age of first pregnancies reported by both those who injected and those who smoked was also young (a mean of 17 years); a total of 76 per cent of the girls and young women had been pregnant at least once in their lives.*
>
> *(Shannon, Spittal & Thomas, 2007, p. 173)*

Women with alcohol or illicit drug dependencies are also more likely to have experienced physical violence as children and as adults compared to women who have never struggled with addictions issues (Miller, Downs, & Testa, 1993). Some women may even experience difficulty in recovering from alcohol and illicit drug dependency because they remain in abusive relationships where addictions are used by an abusive partner to control a woman and keep her isolated (Beckman, & Ackerman, 1995).

Research demonstrates that women who experience physical and/or sexual violence may suffer from post-traumatic stress disorder, a mental health condition characterized by flashbacks, sleeping difficulties, persistent intrusive thoughts, and avoidance of all things associated with the stressful event. In order to cope with the symptoms of post-traumatic stress disorder, some women, if unable to access appropriate mental health services, may turn to alcohol or drugs in order to cope with the distress and to numb the pain. It is of note that women experience higher rates of addiction to painkillers and sleeping pills than men, which has been associated with coping with post-traumatic stress disorder associated with gendered violence (Currie, 2005).

The Aurora Centre, which is a provincial women's treatment program at B.C. Women's Hospital in Vancouver found the following from examining self-assessment forms filled out by resident participants:

> *At the time of entering treatment, 63 per cent of women indicated that, as adults, they had experienced physical violence, and 41 per cent indicated that they had experienced sexual violence. As children, almost half (48 per cent) had experienced physical violence and 46 per cent had experienced childhood sexual abuse. It is not surprising that for 54 per cent of the women, help with violence and abuse issues was rated as "very important to address" in the context of treatment.*
>
> *(Poole, 2007, p. 212)*

Another study conducted by a group of service providers in rural British Columbia, interviewed women and found:

> *...one woman explained her use of cocaine as a means to cope when her second husband became increasingly violent:*
>
> *To numb the pain. To numb the guilt. To numb the failure that I had been feeling. 'Cause two relationships, I knew this wasn't going to last for long. I knew something was going to happen. You could just kind of feel it. Although I didn't want to feel it. So, [using] was burying it....*
>
> *(Varcoe & Dick, 2007, p. 181)*

These studies demonstrate the need for addiction treatment centres to include services that address issues of trauma and the subsequent post-traumatic stress disorder that may evolve. More specifically, this might include trauma counselling, but it might also provide shelters and safe spaces for women and their children in order to enable them to leave abusive relationships. Based on my experience in working in women's

shelters throughout Montreal, I found that often shelters will not accept women who have substance-use issues because they are not able to provide addiction treatment services. Women's shelters work, for the most part, with zero tolerance for alcohol and illicit drug use. This creates a large resource gap. Women who use substances and experience domestic violence are unable to use the services of women's shelters for safety unless they have recovered from their addiction. They are unable to access addiction treatment services that properly address issues surrounding trauma and the need for safe housing.

Studies also demonstrate that alcohol and illicit drug dependency is often in response to the powerlessness incurred by gendered violence. Sexual violence against girls and women oftentimes has to do with the reinforcement of gendered constructions of the female body and its presumed heterosexuality. With regard to sexual violence against lesbian women, Jackie Jones writes in *Gender, Sexualities and the Law*,

> *Anti-lesbian violence often attempts to (re)feminise the female body through the imposition of forced acts of heterosexuality, thus temporarily restoring the established normative connections between sexed bodies, gendered expectations and heterosexual attraction. The frequent connections made between lesbians and masculinity, confirming the abnormality of masculinized female bodies through their lack of femininity, ensure that traditional notions of heterosexual attraction are sustained. In this way, homophobic violence reinforces the differences (in power and, consequently, in role) between differently sexed bodies. (Jones, 2011, p. 151)*

Therefore, this type of violence attempts to both conceal the instability of heterosexual gender norms, and preserve what is seen as the 'gender order' (Jones, 2011, p. 151). Jones writes that such violence can be "understood as a heteronormative discursive practice, perpetually reiterating the centrality and stability of heterosexuality and its

associated gender norms" (2011, p.151). When women who have experienced such violence then turn to substance use in order to cope with the trauma, the stigma associated with women living with addictions plays on the very same powerlessness experienced in the original violence. The stigma of labeling female addicts as sexually promiscuous and having no morals serves to produce, restrain and police heterosexual gender norms.

Women's Bodies as Spaces of Violence

What is even more concerning is that in taking up the label of addict, women's bodies, because of the stigmatizing view that female addicts are sexually promiscuous, in essence, become spaces in which violence can occur with impunity. An example of this is the widely publicized 1983 New Bedford Massachusetts rape case where a 21-year-old mother of two, Cheryl Araujo, was gang raped in a bar while bystanders cheered on the perpetrators, and no one from the bar phoned for help, even though the assault lasted an hour and a half. During the 1984 trial, protesters gathered outside the court house exclaiming that Araujo had asked to be raped because she had exposed herself drunk to men.

This trial was deemed by feminists to be a "blame the victim" trial (where Araujo was grilled on the stand about her alcoholism and her sexual past). Though four men were convicted of aggravated sexual assault, Araujo and her family were ostracized from the community and forced to leave. At the age of 25 years, Araujo, sadly, after being released from an addiction treatment centre, died in a car accident while under the

influence. This tragic story demonstrates how the violence incurred by women with substance-use problems is based on the negative stereotype that women alcoholics and addicts are sexually promiscuous and are therefore, "available" to men.

More recently, in 2011, Manitoba Queen's Bench Justice Robert Dewar gave a man convicted of sexual assault a conditional sentence (meaning no jail time) because the victim had been drinking, had been flirtatious and had dressed in a short skirt and tube top with no bra, which the judge said led the accused to believe that "sex was in the air" (McIntyre, Rape victim 'inviting,' so not jail, *Winnipeg Free Press*, February 24, 2011). This demonstrates how even within the legal system the bodies of women who drink or use illicit drugs are perceived as unworthy of protection.

An array of studies of studies have demonstrated that these kinds of negative perceptions can lead to violence against women living with addictions (Addiction Research Foundation, 1996; Alberta Alcohol and Drug Abuse Commission, 2003; Brown, Melchoir, & Huba, 1999; Brown, Melchoir, Panter, Slaughter, & Huba, 2000; Bush-Baskette, 2000; Byrne & Howells, 2002; Collins & McNair, 2002; Koss, 2000; Substance Abuse and Mental Health Services Administration, 2003; Varcoe, 1998). William H. George and colleagues carried out a number of studies to gauge attitudes towards women who use alcohol (1986; 1988). What they found was alarming. In their first study, they had 96 male college students rate videotapes of young women either drinking a beer or drinking a cola beverage. When the men were asked to rate the women with regard to sexual responsiveness and promiscuity, they gave the highest ratings on both terms to the woman featured in the video who was seen drinking a beer with a male

companion. The men perceived the woman in the video as more likely to be attracted to and to be seduced by them. According to George and colleagues:

> *These results imply that men view a woman's drunkenness as an exploitable weakness. In real-life dating situations, such a biased view of a drinking woman could support or even precipitate unwelcomed sexual advances. Moreover, these perceptual biases could potentially play a mediating role in sexually violent acts that involve a drinking female victim (1986, p. 10).*

George and colleagues later discovered that it wasn't just male college students that held this negative perception, it was also female students. In their second study, 174 male and female university students were asked to fill out questionnaires and read vignettes to gauge their perception of women's drinking. In the vignettes, it was found that compared to the woman drinking a cola beverage, the woman drinking a beer was interpreted both by male and female college students as "more aggressive and impaired, less socially skillful and more sexually predisposed" (George, Gournic, & McAfee, 1988, p. 1316). The misconception that women who drink are more sexually predisposed creates the dangerous view that the bodies of women are open sites for aggression without fear of punishment.

The Production of Prohibited Identities: The Sexualization of Girls and Women

The stigma associated with women who struggle with substance use, and the negative perception that these women are sexually promiscuous, takes place in an environment where the sexualization of girls and women runs rampant. Evidence of this can be found in a myriad of forms of media including television, music videos, music

lyrics, movies, magazines, video games, the Internet and advertising (Gow, 1996; Grauerholz & King, 1997; Krassas, Blauwkamp & Wesselink, 2001, 2003; Lin, 1997; Plous & Neptune, 1997; Vincent, 1989; Ward, 1995). Research has shown that in recent years sexual images of girls and women in mainstream media and popular culture have undergone a drastic shift in emphasis, with women increasingly portrayed as actively embracing and celebrating their status as a sex-object (Gill, 2008). Discourses linking objectification and empowerment play large in mainstream advertising, and target girls as young as three years of age. From La Senza Girl selling young girls 8 to 12 years of age thong underwear and push-up bras, to the most popular doll for girls in North America at this moment (Bratz Dolls) sporting fishnet stockings, thigh-high boots and pumped up glossy lips, this is an era where young girls and women are being taught that positive self-esteem is built on reclaiming sexualized portrayals that modern feminism has sought to challenge. Ariel Levy writes,

> *'How is resurrecting every stereotype of female sexuality that feminism endeavoured to banish good for women? Why is laboring to look like Pamela Anderson empowering? And how is imitating a stripper or a porn star — a woman whose job it is to imitate arousal in the first place — going to render us sexually liberated?' (2005, 3-5)*

In popular culture, notions and values that women can use their bodies for profit as a means of accessing power run rampant. Marjut Jyrkinen (2005) notes that these values have become increasingly consistent through the globalization of Western culture, creating a context of normalization that she refers to as "McSexualization."

Linking self-sexualization or objectification with feminism and empowerment falsely creates the notion that gender equality has been achieved. The message young girls are getting is that sexualized bodies are valued and rewarded over other personal achievements, and the notion of "girl power," which associates self-sexualization with being empowered, conceals the real social relations of power that are at play.

Societal messages that contribute to the sexualization of young girls and women are not simply being reflected in media alone, girls are also receiving these messages through their interpersonal relationships, including with parents, teachers, and peers (Brown & Gilligan, 1992). The American Psychological Association reports that parents may contribute to the sexualization of girls when conveying messages about the importance of attractiveness to little girls, and even encouraging plastic surgery to help girls meet these types of goals (2010). Research has also demonstrated that some teachers encourage young girls to take up sexualized performances pretending they are adult women (Martin, 1988), and may even hold stigmatizing beliefs that girls of colour are "hypersexual" and therefore less likely to achieve academic success (Rolon-Dow, 2004). Research has also demonstrated how both female and male peers contribute to the sexualization of girls. With regard to female peers, girls tend to police one another in order to ensure conformance with standards of sexiness and thinness (Eder, Evans, Parker, 1995; Nichter, 2000); and with regard to male peers, boys may sexually harass or objectify girls. Therefore, girls end up policing themselves, and they also end up being police by their female peers and in addition to being policed by a multitude of authority figures, as well as male peers, in their lives. On the extreme end of contributing to the

sexualization of girls, there are reports of sexual abuse and exploitation of girls at the hands of parents, teachers, and peers (American Psychological Association, 2010; Statistics Canada, 2011) .

Unfortunately, statistics show that girls are purchasing or requesting that their parents purchase products and clothing designed to make them appear more "sexy." They are working to style their identity after the sexy celebrities that fill their cultural landscape, not realizing they are, in fact, in the process of sexualizing themselves. The American Psychological Association writes that girls sexualize themselves when they think of themselves in objectified terms (2010). Psychological researchers have found that self-objectification has become a key process in the lives of girls, with girls thinking of their bodies and treating their bodies as objects of others' desires (Frederickson & Roberts, 1997; McKinley & Hyde, 1996).

> *In self-objectification, girls internalize an observer's perspective on their physical selves and learn to treat themselves as objects to be looked at and evaluated for their appearance. (American Psychological Association, 2010, p. 1)*

Research has demonstrated that self-objectification has cognitive and emotional consequences for both girls and women (American Psychological Association, 2010), and that self-objectification can affect a girl's and woman's ability to concentrate and focus, leading to poor performance in mental activities such as mathematics and logical reasoning (Frederickson, Roberts, Noll, Quinn, & Twenge, 1998; Gapinski, Brownell & LaFrance, 2003; Hebl, King & Lin, 2004). With regard to emotional consequences, it has been found that the sexual objectification of girls and women negatively affects self-

confidence and comfort in one's own body, leading to shame, anxiety, etc. (Slater & Tiggemann, 2002).

Research has also demonstrated that the increasing sexualization of girls and women has severe consequences on mental health, including eating disorders, low self-esteem and depression (Abramson & Valene, 1991; Durkin & Paxton, 2002; Harrison, 2000; Hofschire & Greenberg, 2001; Mills, Polivy, Herman, & Tiggemann, 2002; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Thomsen, Weber & Brown, 2002; Ward, 2004). The sexualization of girls and women has also been shown to have an impact on healthy sexual development, with research linking self-objectification with diminished sexual health practices among youth (e.g. a decrease in condom use, and diminished sexual assertiveness) (Impett, Schooler & Toman, 2006). The very narrow ideals of the female sexualized body have also been shown to bring about feelings of shame in girls and young women which may cause sexual problems later into adulthood (American Psychological Association, 2010).

The sexualization of girls and women in media and popular culture can be seen as a continual reinforcement of gendered constructions of the female body and its presumed heterosexuality. It works to establish normative connections between sexed bodies and gendered expectations. And through the repetitive exposure of girls, women, boys and men to media messages that sexualize girls and women, heterosexual gender norms come to appear "natural," thus concealing their instability.

The reality is that current statistics on the prevalence of child sexual abuse report that one out of every four girls will experience some form of sexual violence before the

age of 18 years (Statistics Canada, 2011). And yet when girls and women respond to the trauma of sexual violence by way of addictions, the stigma levelled against them is that they are "sexually promiscuous," "hypersexual," and have "loose morals." Therefore, an environment is created where girls' and women's bodies are sexualized, which opens their bodies up as sites for sexual violence to occur, thus creating a vicious circle.

Any work to combat the stigma associated with addictions must therefore critically look at: 1) the ever-increasing sexualization of girls and young women and its impacts; 2) the violence that occurs against women living with addictions; and 3) the discourses surrounding women and addictions, and bodies that are perceived as "worthy" and bodies that are perceived "unworthy." This is discussed further in Chapter 5.

4.3 Pregnant and Mothering Women and Addictions

I turn now to the stigma associated with pregnant and mothering women struggling with addictions issues. It has been written that nowhere else has women's behaviour been so policed and restrained by normative regulations than in discourses and practices around motherhood (Schur, 1983). For pregnant and mothering women living with substance-use problems, the negative stereotype of sexual promiscuity and loose morals can give rise to or accompany the "bad mother" stereotype. This is demonstrated in mainstream media, where pregnant and mothering women who use substances are often portrayed as monsters. This is demonstrated in courts, where pregnant and mothering women living with addictions are often seen as criminally responsible for their predicament and seen as *a risk* to their child. This is also demonstrated in health care

institutions, where pregnant and mothering women who struggle with substance dependency confront barriers to accessing appropriate treatment and care because of negative perceptions held by health care workers. They also face the threat of losing their children if they seek care.

According to the 2001 Canadian Community Health Survey, 12 per cent to 14 per cent of women surveyed reported using alcohol during their last pregnancy (note that due to fears that disclosure of alcohol or illicit drug use during pregnancy will lead to the removal of women's children, these statistics may not be completely accurate). It has been estimated that 18 per cent of mothers who are involved with the child welfare system have alcohol-use problems, and 14 per cent of mothers have other substance-use issues (vCoP, 2010). This demonstrates how pregnant and mothering women living with addictions are a reality within the Canadian landscape, and deserve our attention.

Mothering, Addictions and Mainstream Media

For most of us, one of the ways we learn about the world around us is through mass media. From local stories to international events, media affects our understanding of people and places near and far. The far-reaching power of media is not simply about connecting people from around the world. Media does not simply provide us with a window to gaze upon a certain event in which we were not present. It even goes beyond providing us with the language and words to interpret and understand a situation. Media reflects and produces (participates in the construction of) social norms that then affects how policies are developed and enacted.

As discussed in previous chapters, power, and those individuals who exercise it, has the capacity to create large-scale systems of thought that can exert a considerable amount of influence on people (Oliver, 2010). Mainstream media produces and restrains social norms. This ideological function is concealed by the concept of "journalistic objectivity," or the idea that journalists can watch an event take place, suspend all personal judgment and bias and describe the event to the audience in an impartial, "objective" way. Even the format of a news story, which answers the who, what, when, how, and why of an event, actually works to conceal the fact that beneath every word, sentence and paragraph lies a carefully constructed version of reality that both produces and restrains identities, and polices and enforces heterosexual gender norms.

This is exemplified in the way that mainstream media often portrays pregnant and mothering women living with addictions. Evidence of this policing and restraining by normative regulations can be seen in the social reaction towards pregnant and mothering women struggling with substance dependency. Public discourses and policies surrounding pregnant and mothering women who use licit and illicit drugs are oftentimes judgmental, blaming and unsympathetic. This is demonstrated in Lorraine Greaves et al. research titled *A Motherhood Issue: Discourses on Mothering Under Duress* (2002). In their analysis of print articles from two national newspapers and one local newspaper in Canada, Greaves et al. found that substance-using pregnant and mothering women were consistently seen as *the risk* to their children. They found that 87 per cent of the articles analyzed portrayed the child or fetus as *at risk* related to exposure to substances, while the pregnant and/or mothering women were presented as *at risk* in only 13 per cent of the

articles (Greaves et al., 2002). Greaves et al. found that this view of mothers extended beyond the idea of being *a risk* to their child, towards an extreme lack of sympathy for their predicament, placing all responsibility on the shoulders of the pregnant and mothering women (Greaves et al, 2002, p. 28). By placing responsibility solely on the addicted woman and then linking such addictions to being a risk to her own child, one is constructing an image of a woman who is intentionally hurting her child, a "monster mother."

These types of discourse produce and maintain the binary concepts of "good mother" and "bad mother," and are directly related to heterosexual gender norms. The negative perception that women with addictions are sexually promiscuous and have loose morals goes to the heart of what is defined as "respectable femininity," and therefore, a pregnant or mothering woman with substance-use problems is portrayed as a bad mother, because women, especially mothers, are believed to be those who uphold societal morals.

Greaves et al. found that the hateful and hostile words spoken about pregnant and mothering women with substance-use problems wasn't simply coming from letters to the editor from child/fetus advocates, but rather journalists themselves were creating and producing the concept of "bad mother" or "monster mother." In their analysis they found that in the majority of articles that concerned pregnant or mothering women with substance dependency, the mother was portrayed as responsible for the situation being reported.

Journalists can sometimes conceal their part in the construction of the stigma against pregnant and mothering women with addictions by interviewing subjects that will

perhaps raise questions about an addicted woman's suitability as a mother. They might for example speak with someone who will reflect the idea that overcoming an addiction is about moral willpower and fortitude, or moulding a story around one subject's perspective that reflects the negative stereotype which links addictions in women with sexual promiscuity, a loosening of morals and bad mothering.

When Greaves et al. examined the articles for who was identified as the "authority" in the situation being reported (people who the journalist referred to as experts in the case), they discovered that articles about pregnant or mothering women who use substances drew the most diverse range of authorities. These "authorities" included women's advocates, children's advocates, judges, parents, medical personnel, reporters and researchers (Greaves et al., 2002). Of the 30 articles analyzed, in over two thirds the voices of authority were identified as researchers, medical experts, professors, court personnel, government policy makers and other professionals (which will be discussed later) (Greaves et al., 2002). Researchers were the most often cited, demonstrating the value placed on "scientific evidence" that focuses on simple behavioural issues (while overlooking health, economic, and social dimensions) in explaining the very complex problem of addictions in women (Greaves et al., 2002). Researchers, judges and prosecutors were the next most quoted, demonstrating the link to the overarching theme of deviance and criminality of women's substance use (Greaves et al., 2002, p. 32). An example of this theme can be found in an essay in Joan Smith's book, *Misogynies* (1989), which discusses the case of Peter Sutcliffe, known as the Yorkshire Ripper, an infamous serial killer who was convicted of murdering 13 women

in the United Kingdom in 1981. Smith writes how in the media the police treated the murdered women who worked in the sex trade, many of which had substance use issues differently than the murdered women who did not work in the sex trade and did not struggle with addictions. A senior detective, Jim Hobson, was quoted by media,

> He has made it clear that he hates prostitutes. Many people do. We, as a police force, will continue to arrest prostitutes. But the Ripper is now killing innocent girls. That indicates your mental state and that you are in urgent need of medical attention.
>
> *(Joan Smith, Getting Away With Murder, New Socialist, 10, 12, (May/June 1982)*

This demonstrates how police were not as concerned about the murder of female addicts who worked in the sex trade compared to the murder of women who did not work in the sex trade or struggle with addiction issues, stating that one would only question an individual's mental state if he were killing women who were not addicts and prostitutes. This type of discourse helps shape the construction of which identities are seen as worthy and grievable and which identities are seen as unworthy and ungrievable.

When examining the articles for who was identified as the "authority," Greaves et. al found that child advocates had strong voices in letters to the editor and opinion pieces, though advocates on behalf of the women were rarely quoted. They also found that the pregnant or mothering women in the articles were never treated as authorities of their own situation (not one pregnant or mothering woman was quoted), therefore, demonstrating how women living with addictions can be perceived as unable to hold authority over their own lives.

Race and class also play a significant role in the negative portrayal of pregnant and mothering women in mainstream media. Stigma is a multi-layered structure where

membership in other stigmatized groups such as a low socioeconomic class, make a unique contribution to the stigmatization of substance use. Schur outlined that people or groups who have fewer resources are less likely to be able to resist stigmatizing labels or to challenge the organizational body applying the label (1985). Substance dependency in people living in poverty, or substances which are associated with socially marginalized groups are considered in mainstream media and elsewhere as "more deviant" than drug use among individuals in the upper class (Clinard & Meir, 1992, p.150). Clinard and Meir write that:

> *Potentially stigmatizing marks have a vastly different fate depending on whether they are associated with high or low social status — with wealth, prestige, and 'winners,' or with poverty, ignorance and 'losers.' Certain 'deviant' behaviours are inherently expensive and may take on cachet because of that. The use of cocaine seems almost restricted to the wealthy, and users are, by and large, less stigmatized than heroin addicts. One reason for this may be the association of heroin with squalid surroundings and 'buys' financed by muggings and larceny. The popular image of cocaine does not include such discordant notes. (Clinard & Meir, 1992, p. 150)*

In Greaves et al.'s analysis, 33 per cent of the articles about pregnant and mothering women with substance dependency issues mentioned race and class; in three instances people were identified as middle class and in seven instances substance use was linked to working class or Aboriginal status (2002). They found that in the articles that mentioned class but not race, pregnant women and mothers who use substances were portrayed as on welfare with no desire to work (responsibility being placed solely on the shoulders of the

women again and not discussing the implications of poverty). Greaves et al. found that when racialized groups were identified, it was most often connected with lower class status. In articles about fetal alcohol syndrome, Greaves et al. found that the articles often linked the syndrome to being socially disadvantaged and of Aboriginal decent (2002). One of the articles even went so far as to use an unsubstantiated statistic that fetal alcohol syndrome was 10 times more prevalent in Aboriginal communities. Such racist stereotypes only bring pregnant and mothering Aboriginal women who use substances under more intense scrutiny without discussing the current supports needed (which includes addressing issues of racism and poverty) to assist Aboriginal women in helping to improve their health and the health of their families.

Similar racist stereotyping of pregnant and mothering women with substance dependency issues was also a point of focus noted in the 1980s in the United States with regard to the frenzy over "crack babies." Humphries looked at the media presentation of crack and cocaine use among pregnant women in the United States, and identified that in the mid-1980s a stereotype emerged of the pregnant crack user as African American, poor and on welfare (1999). Humphries argued that the media fury over "crack babies" served a political agenda which focused on social welfare cuts, noting "Fiscal conservatism fuelled by racist and sexist images of poor women of color justified cutbacks in social services in the 1980s" (Humphries, 1999, p. 18).

The construction of women's identities as "worthy" and "unworthy" as it is related to addictions and stigma is another dimension. In Greaves et al.'s analysis they found that news articles established such judgments by clearly identifying who is the

victim and who is responsible for the victimization. Compared to articles written about women living with mental illness and women living in abusive relationships, articles written about pregnant and mothering women who use substances held the woman solely responsible for their own and their child's situation and were portrayed as willful and abusive towards their child (Greaves et al., 2002). Unlike articles about women living with a mental illness, articles about pregnant and mothering women with a substance dependency did not hold the system responsible at all for their situation (with regard to women living in abusive relationships, the system was also not held responsible, though not to the same extent as women living with addictions). In stories about pregnant and mothering women with substance-use problems, the need for services for children for problems that might arise as a result of the mother's substance use, such as fetal alcohol syndrome, were highlighted, but never the need for compassionate addictions treatment services that respond to the particular needs of pregnant and mothering women. By this exclusion, pregnant and mothering women living with substance-use issues were portrayed by the mainstream media as unworthy of the very necessary treatment services needed, and their children were seen as worthy victims in need of protection from their mothers. Such beliefs lead to punitive mothering policies, as I discuss in the next section, that polarize the needs of women and the needs of their children.

Mothering, Addictions and the Law

The stigma associated with women living with addiction issues, especially the negative stereotype that pregnant and mothering women with substance-use problems are "bad mothers," also shapes policies and the law. An example of this would be the case of "Ms. G" in Winnipeg, Manitoba. In August 1996, Winnipeg Child and Family Services brought a case against a pregnant mother of three children to court. The woman, known as "G," was a 23-year-old First Nations woman from Winnipeg, who, at five months pregnant with her fourth child, was court-ordered to detention and treatment for a substance-use problem "to prevent harm to the unborn child." Winnipeg Child and Family Services argued that two of the woman's previous children had suffered brain damage as a result of the woman's addiction to sniffing solvents such as glue, nail polish remover and paint thinner. The court ruled that the woman was not mentally competent. A superior court judge ordered that the woman be placed in the custody of the Director of Winnipeg Child and Family Services and detained in a health centre for treatment until the birth of her child. Yet it was revealed soon after that a court-ordered psychiatric report found the woman was, in fact, deemed mentally competent. Ms. G appealed the decision.

In September 1996, the Manitoba Court of Appeal unanimously reversed the decision of the lower court in the case of Winnipeg Child and Family Services versus G. It was ruled that courts cannot order a mentally competent person to undergo treatment against her will. But in October 1996, the Supreme Court of Canada granted leave to hear the appeal of Winnipeg Child and Family Services in the G case. By the time the case

was scheduled to reach the Supreme Court, the woman known as "G" had already given birth to her baby — a healthy boy named William.

In June 1997, the case was heard by the Supreme Court of Canada. Both sides of the case had twelve intervenors[i] present. Intervening on behalf of the woman known as "G" were the Women's Health Rights Coalition, consisting of the Winnipeg Women's Health Clinic, Métis Women of Manitoba, the Native Women's Transition Centre and the Manitoba Association of Rights and Liberties. Also intervening on behalf of the woman were the Women's Legal Education and Action Fund, the Canadian Abortion Rights Action League, the Canadian Civil Liberties Association, the Aurora Centre and the British Columbia Centre of Excellence in Women's Health.

According to Nancy Poole, a consultant with the Aurora Centre at the Children's and Women's Health Centre in British Columbia at the time (and who has since become the co-executive director of the British Columbia Centre of Excellence in Women's Health), the organizations had agreed that it was critical to challenge the widespread view that pregnant women with addiction problems are incompetent and incapable of choosing recovery. The organizations also wanted to highlight that the health interests of the mother and child are inextricably linked. Poole wrote that the array of organizations that intervened on behalf of Ms. G wanted to draw attention to the effectiveness of programs that take caring, welcoming and empowering approaches to pregnant and mothering women who use alcohol and/or other drugs, and to stress that these programs are few and far between in Canada. And though much of the mainstream media portrayed Ms. G as being an unfit mother, there were independent media and non-profit organization

publications that worked hard to counter such media coverage, to offer an alternative discourse, to bring humanity and a deeper understanding to the issue, with quite nuanced and sympathetic coverage.

Arguments submitted by the Women's Health Rights Coalition on behalf of Ms. G included the fact that pregnant women living with addiction issues would not access appropriate prenatal care and addiction services if they felt physicians would report them and there was a potential of losing their child. They also pointed out that "healthy public policy" requires broad initiatives to attack the underlying social causes of addiction, such as the relationship between poverty and addictions as well as trauma and addictions. The Women's Health Rights Coalition also pointed out that it has been recognized that traditional addiction treatment methods, such as Alcoholics Anonymous, are based largely on the experiences of men and are not always appropriate for women (especially for pregnant and mothering women and women who have experienced violence).

In October 1997, the Supreme Court of Canada ruled seven to two that courts cannot force a pregnant woman to undergo treatment to prevent harm to her fetus. Yet the court of public opinion blasted a very different sentiment, one of anger and disdain towards the woman, equating her to a "monster mother" of sorts. There were calls for harsher punishment reverberating in letters to the editor in mainstream media, and journalists themselves reinforcing, with every word, the "good mother" and "bad mother" dichotomy (as discussed above).

And though this case created a precedent still not seen in the courts in the United States, where pregnant and mothering women living with addictions can be court-ordered

and detained in addiction treatment facilities against their will, women with addiction issues still make up a large proportion of the Canadian jail population.

Pregnant and mothering women with substance-use issues are most often criminalized and incarcerated for crimes that are related to poverty and substance use. It has been found that approximately two-thirds of Canadian female inmates are mothers of children younger than five years of age (vCoP, 2010). It has been estimated that 25,000 Canadian children are affected by their mother's incarceration each year (vCoP, 2010). Pregnant and mothering women who use substances and have been incarcerated face a myriad of harms and barriers including feelings of guilt and depression related to the stigma they face, and an increase in drug and alcohol use. It has also been shown that women who have been separated from their children are more likely to be re-incarcerated in the future. Research demonstrates that Aboriginal women are most affected by these barriers because there is a disproportionate representation of Aboriginal women incarcerated in Canada (vCoP, 2010).

Policy espoused by the Canadian federal government also does not take into account the stigma experienced by women with addiction issues. Working to combat stigma associated with addictions runs counter to the conservative federal government's tough-on-crime legislation, which continues to call for tougher punishments without looking reflecting upon who makes up the prison population. A 2008 piece in the *Toronto Star* revealed that more than 70 per cent of individuals in prison have not completed a high school education, 70 per cent of the prison population have had unstable job

histories, 73 per cent of homeless people surveyed have done prison time and four out of every five prison inmates have serious substance-use issues.

I would contend that stigmatizing attitudes towards people living with addiction issues as well as issues of gender, race, class, and socioeconomic status play a large part in who is incarcerated in Canada and who is not. Canada is one of the few developed nations where the federal government does not allot a certain amount of the budget to invest in low-income housing. Instead of investing large amounts of money into tough-on-crime legislation it might be wiser and of more benefit to all Canadians to invest money into low-income housing, increasing minimum wage, and other ways of combating sexism, racism and classism. The failure to do so is directly related to the stigma associated with addictions and which identities are socially constructed as worthy and which identities are constructed as unworthy.

Mothering, Addictions and Health Care Institutions

For pregnant and mothering women living with addictions, the fear of being stigmatized by health care professionals and social workers plays a large part in the barriers that impede them from accessing appropriate addiction treatment care. In a qualitative Canadian study that explored the social effects of drug use among mothers, results from in-depth interviews with mothers about their experiences with health and social services revealed that women living with addictions experience a large amount of stigma during their prenatal and antenatal health care visits (Boyd, 1999). Some women

identified difficulty in accessing accurate information about the risks associated with continuing use of specific drugs during pregnancy, including methadone, on their fetus (Boyd, 1999). Other women reported being treated with a great amount of disrespect by physicians and other health care professionals during prenatal visits and childbirth (Boyd, 1999). Similar to Boyd's research, a study conducted by Copeland (1997) which also involved in-depth interviews with women struggling with addiction issues found that, as a consequence of the stigma associated with substance use, the women reported that they often did not mention their addiction issues with their general medical practitioners even when directly relevant to their health. In Boyd's study, women who received social assistance reported that once they were labelled as illicit drug users they were "denied services and treated with less respect" (1999, p. 120).

When dealing with social workers, the greatest concern for women interviewed in Boyd's study was losing their children to the Children's Aid Society.

> *The women interviewed stated that social workers were ill-informed about illicit drug use, and their misconceptions coloured their decisions. Mothers were often denied custody of their children because of their history as illicit drug users. There was little room for negotiation, and mothers stated that there was no way to 'prove' that they were capable of caring for their children once they had been labelled as illicit drug users.*
>
> *(Boyd, 1999, pgs. 128-129).*

4.4 Resistance

Goode once wrote that having an identity that is perceived as "deviant" is difficult to change as the stigmatized label is "sticky" (1984, p. 35). It is said that there are many

"symbolic ceremonies" throughout the labelling process being diagnosed as having an addiction, being arrested because of that addiction, or being admitted to a treatment centre and labelled an "addict." Yet, it has also been said that there are no equally powerful ceremonies which de-stigmatize and reintegrate an individual who chooses to relinquish the perceived "deviant behaviour" (Goode, 1984, p. 34). Goode writes, "Nothing has happened to cancel out the stigmas that society has imposed" (1984, p. 35).

These "symbolic ceremonies" can be seen as "hailings" to the identity of an "addict." In 1970, Louis Althusser, a Marxist philosopher, introduced the concept of "interpellation" in his book *Ideology and Ideological State Apparatuses (Notes Towards an Investigation)*. Interpellation is the process by which individuals come to recognize themselves as belonging to a certain identity. It is the way in which identities, roles and activities are "conferred through the authority of established ideologies and social practices" (Aston, 2009, p. 614).

Althusser uses the example of a policeman yelling out to a passerby in the street. The policeman, who is seen as an authority figure, is hailing the passerby. This in Althusser's interpretation means that an ideology recruits the passerby and if the passerby responds and begins to engage, which is almost inevitable, the passerby is transformed into that particular identity. In short, s/he is accepting the social role being offered to her/him.

In *Undoing Gender* (1995), Judith Butler elaborates and expands on the concept of interpellation using the example of when a child is born and the doctor exclaims, "It's a girl!" Before the exclamation, the subject does not exist, until the doctor "hails" the

child to take up the identity of a girl by proclaiming "It's a girl!" The subject, including the subject's body is thusly constituted or produced as a girl and the individual is forced in a way to take up all of the expectations and traits expected of a "girl."

Where Butler expands on Althusser's concept is when she suggests that the interpellation process is far more complex and subtle than what Althusser set out to describe (i.e. that of the policeman hailing a passerby). For Butler, 'the voice of interpellation' or the voice of authority that hails the subject to accept an identity may not be 'singular, easily recognizable, or 'impossible to refuse' such as God or a policeman' (1995, p.10). The hailing may not be a single event, but rather multiple authorities and ideologies. It may also happen over a long-drawn out time period rather than a quick one-time event that transforms the subject into a particular identity. Butler also points out that interpellation cannot be one-sided — that an individual must firstly be able to recognize themselves as being hailed, and then have some sort of openness or vulnerability to the authority that is doing the hailing (1995, p.32).

In "Identities under construction: Women hailed as addicts," Shaughney Aston explores the "power of hailing, where hailing lies, and how hailing operates in discourses about addiction that appear in women's talk of their encounters with addiction services and supports" (2009, p. 611). Aston examines in her article the ways by which gender operates as "both condition and effect of interaction that intersect and generate complex social meanings and identities, and get women's attention in terms of seeing themselves as addicts" (2009, p.611).

Aston based her research on numerous interviews with women who identify themselves as addicts (many of the women Aston interviewed identified as alcoholics) living in rural communities. Aston discussed with the women the process by which they took up the identities of an "addict." For many women, it involved numerous, accumulating encounters with a number of authorities such as counsellors, doctors, educational films, the Alcoholics Anonymous (AA) Big Book About Addictions, etc. After several years and a variety of encounters, for many of the women "the message got through" and the women began to see themselves in a new way, as "an addict" (Aston, 2009, p. 620). Many of the women began to "align their voices with the expert knowledges of the authorities," those of western medicine and Alcoholics Anonymous (Aston, 2009, p. 621).

Just like Butler's example of when the doctor exclaims, "It's a girl!" these women, when saying "I am an addict," became addicts just by saying so and accepting the identity. For some women, there was a huge sense of relief in identifying as an addict, because with it came explanations of why they behaved in certain ways. They had finally located something tangible, in the words of Alcoholics Anonymous, they had "an incurable, progressive and fatal" disease (Aston, 2009, p. 618). In treatment, women felt a reduction in shame because the medical system finally validated their problem as a disease and the women no longer looked at addictions as if they had a behavioural problem (Aston, 2009).

Aston wrote that it became clear looking back at all of the interviews that women had "a lot of help with their identity projects" with "multiple authorities working

unknowingly together over a number of years to hail them toward their new identities" (2009, p. 621). But through her interviews with women, she found that there were women who resisted being hailed and accepting the identity of "an addict." These women who found it difficult to recognize themselves as belonging to the category of "addict" defined by western medicine and Alcoholics Anonymous, could then be, as Aston points out, described as "failed performative" responses to interpellation (2009, p. 621).

But why did these women resist being hailed as "addicts?" One woman found that the dominant views of both addiction services and Alcoholics Anonymous, that "addiction was a disease," did not coincide with her feminist values. Though this woman showed evidence of being ready to be hailed, describing the classic "hitting rock bottom" (a term used in Alcoholics Anonymous to symbolize the moment where an addict's entire world unravels because of the alcoholism, forcing them to seek treatment), she felt that the problem of addiction did not lie within the individual with the addiction but rather within a "patriarchal, capitalist discourse."

Aston discovered that this woman believed the addictions discourse was patriarchal because it refused to "recognize gender power imbalances" and was capitalist because of its "constant urgings to alter" one's "feeling states" through the "endless pursuit of material consumer goods" (2009, p. 622). According to this woman, "...it is impossible for any woman to feel contentment with her 'reality' while living within a patriarchal and totalizing discourse 'superimposed on women' that refuses to 'recognize that (they) have specific issues and might need a slightly different hand" (Aston, 2009, p. 622).

These women resisted accepting membership to the identity category of "addict" as defined by addiction services and Alcoholics Anonymous because the views being espoused by such services and organizations were based on powerlessness and character defects. Alcoholics Anonymous is about handing over one's power to a higher power in which you have faith (e.g. God, Buddha, Allah, nature, etc.), admitting your powerlessness to the disease, and acknowledging your various character defects such as selfishness, the need to be the centre of attention, the need to be in control, etc. One woman noted that she resisted this definition of "addict" because powerlessness was "what women have been doing for years" (Aston, 2009, p.622). This woman felt that dealing with her addiction was about examining the effects of power imbalances and oppression in her life rather than accepting the definition of "an addict" through addiction services based on a "male-paradigm" (Aston, 2009, p. 622). One woman went out in search of a therapist who was able to provide her with the language to see herself and her substance-use problem in ways that were aligned with her own political beliefs. To her, addiction wasn't a chronic disease but rather a short-term coping mechanism to deal with the violence perpetrated by power imbalances in her life.

This demonstrates that with mainstream media which, as discussed above, often negatively portrays or stereotypes women struggling with substance use, also come competing discourses and systems of thought that, through technologies such as the Internet, are becoming more accessible to the general public. This accessibility encourages individuals to begin their own personal archaeology, exposing the underlying relations of power that exist both in our inter-relationships and our relationship with

social institutions, so that resistance to being hailed can be achieved. With new media, such as Wikipedia, which allows for the exchange of thoughts, individuals have more access to knowledge that used to be only accessible to psychiatrists and physicians who would subsequently accrue power because they were seen as the keepers of such knowledge.

Aston demonstrated in her research that there were women with substance-use problems who refused the social roles offered to them by the established addictions ideologies, and refused to be transformed into a subject lacking power. In doing so, these women found alternative solutions to their substance-use problems. By rejecting the gender-neutral interpellative identity these women found room to take up the identity of "an addict" in new and unexpected ways.

Chapter 5 Mental Illness, Stigma and Heterosexual Gender Norms: Final Recommendations

> *Let's face it. We're undone by each other. And if we're not, we're missing something. If this seems so clearly the case with grief, it is only because it was already the case with desire. One does not always stay in tact. It may want to, or does, but it may also be that despite one's best efforts, one is undone, in the face of the other, by the touch, by the scent, by the feel, by the prospect of the touch, by the memory of the feel. And so when we speak of* ***my*** *sexuality or* ***my*** *gender, as we do (and as we must) we mean something complicated by it.*
>
> *(Butler, 2004, p.19)*

One does not always stay intact. Despite one's very best efforts, one may, at some point of time in life, come undone. A tremendous loss may occur — a loss of a loved one, a loss of a home, a loss of employment, a loss of sense of self. Physical, emotional, verbal and sexual violence (including racism, homophobia, sexism and classism) can create lasting effects that may remain imprinted on our bodies, our psyches, or our souls. Such violence can create, for the individual it has been directed at, a deep sense of loss — a loss of control over one's body, a loss of control over one's thoughts, a loss of control over one's words. Such violence brings about a sense of powerlessness, a loss of agency, a loss of self. And for those individuals who have experienced such trauma, this loss may then be taken in, introjected, so one becomes this loss. One becomes undone. People may respond to this undoing in a myriad of ways in order to cope. They may employ both the ways they have been taught to respond as well as the options that are available to them in order to respond. People may respond to this undoing by turning to behaviours that have

been classified as the behaviours of an addict, or behaviours that have been classified as the behaviours of a person who is mentally ill.

As a society, there is a great reluctance to talk about, to deal with, to confront head on, grief and grieving. It is easier to try to conceal grief, and to use grief to meet other ends. Individuals who respond to loss or to trauma in particular ways are labelled as mentally ill and/or addicts. People who have experienced trauma and subsequent loss because they do not fit into the tightly confined and defined borders of heterosexual gender norms, such as individuals who identify as transgender, are further stigmatized as they are labelled as mentally ill. Women who have experienced violence, including childhood sexual violence, who respond to such trauma by way of substance use, are labelled as addicts. The stigma associated with this label, for women, using the same violent loss that was introjected by these women against them again in order to police and restrain heterosexual gender norms.

Instead of viewing these responses to loss, to trauma, to violence, as just that, categories and labels have been created in order to conceal the fact that people are being harmed by enforcement of dualistic heterosexual gender norms. On top of this, the stigma associated with these labels is used to restrain and police heterosexual gender norms in order to continually obscure that these are responses to trauma — this is what grief looks like.

It is not about who is responsible and who should take responsibility, which is what stigmatizing attitudes and behaviours against individuals labelled as mentally ill and/or as addicts thrive on. But it is about our collective "response-ability." Anti-stigma

campaigns, including the Mental Health Commission of Canada's *Opening Minds* initiative, need to begin to move away from normalizing the labelling of responses to trauma, and begin to work towards both providing individuals who have experienced such loss with alternative ways to respond, and arming our communities with the knowledge of how to support and help individuals share their experiences of grief.

This may include acknowledging the fact that these responses to trauma have been classified and defined in ways that help to produce, restrain and police heterosexual gender norms and that stigma associated with such labels has also worked towards the same goal. Doing so enables the realization that individuals who have experienced the perpetration of violence against them in order to preserve the illusion of a heterosexual gender order, are doubly traumatized when their responses to such loss are labelled in such a way that the stigma associated with the label is used to preserve the exact same illusion.

The following are some recommendations and special considerations for regard to combating the stigma associated with mental illness and/or addiction, from a place of "response-ability."

5.1 Response-Ability in Our Words

Anti-stigma campaigns are a hailing of sorts. They hail us to take up the identity of an addict or someone who is mentally ill without ever questioning the validity of such labels and their associated stigma. Foucault was fascinated by the relationship between discourse, knowledge and power. He wrote about how power, and those individuals who

exercise it, had the capacity to create large-scale systems of thought that could exert significant influence over individuals' lives (Oliver, 2010). To Foucault, it wasn't necessarily about overturning power structures but rather questioning and exposing the nature of power, and analyzing its mode of function.

Foucault showed how concepts such as "insanity" or now "mental illness" changed over a long period of time, and how, even though the word would stay the same, the ideas represented by the concept changed. By doing so, he exposed how concepts such as "insanity" were, in fact, social productions. In *The History of Sexuality* (1979), Foucault writes about how during the Victorian era, changes were made to the way in which we discussed sex, though it was still possible to discuss sex, the vocabulary and the nature of the discourse changed. Many of the explicit and precise words used to describe sex were replaced by expressions that were either imprecise or euphemisms. One begins to think that maybe concepts such as "mental illness," "addiction," "depression," "post-traumatic stress disorder," etc. are being used in order to discuss matters of grief in what has been deemed as a more appropriate, or acceptable way.

The question then becomes, do these words exist for us to make meaning of our own lives, or do they exist for others to make sense of us? In taking up these identities, of addict or mentally ill, are we in turn dispossessed? And in this sense, is it a way of being for another? Traditional anti-stigma campaigns want us to come forward, want us to take up this identity, want us to confess our hurt, but only using the words in their prescribed terms. For example, as discussed in Chapter 3, how individuals who identify as transgender, and who desire to have sex-reassignment surgery, must tell their stories in a

way that conforms to the diagnosis of gender identity disorder in order to access surgery. When we are forced to tell our stories, lay bare the raw and seemingly untouchable parts of our hearts, by using words that are not our own, the space between the words and our being becomes thick with loss. Is this how we grieve in a socially acceptable way?

And yet, there are sites of resistance. There are individuals resisting being hailed, and resisting taking up the identity of addict or mentally ill. They recognize that these labels are being used only to conceal the very grief caused by the denial of the diversity and fluidity of gender. And it is with words that we can begin to paint a very different landscape when it comes to such trauma.

The questioning of the stability and constructedness of the gender categories "girl," and "boy," "woman" and "man" by feminist post-structuralist theorist Judith Butler may aid in the unravelling of stigma associated with mental illness and addictions. With the deconstruction of the categories of "man" and "woman," we start to observe the connections between the stigma associated with mental illness and addiction and the policing and restraining of heterosexual gender norms. For example, the signifier "woman" (which Butler would argue has no inherent connection to the body it is referring to) when connected to the signifier "addict" is simultaneously connected to signifiers associated with sexual promiscuity (i.e. "slut," "whore," etc.). These signifiers are, in and of themselves, a violent assault against the referent, especially if the referent's substance use issues are in response to the trauma of sexual violence. Signifiers of this nature open the referent up to more violence. Another example would be, the signifier "man" (which Butler would argue has no inherent connection to the body it is referring

to), when connected to the signifier "mentally ill" is simultaneously connected to signifiers associated with weakness, fragility and femininity. A potential concept for an anti-stigma billboard campaign could be:

woman + addiction = slut?	man + mental illness = weak?
man + addiction = slut?	woman + mental illness = weak?

This might begin to destabilize the connections made between the signifiers "woman," "addict," and "sexually promiscuous," as well as those made between the signifiers "man," "mental illness," and "weakness." In so doing we may expose the reality that this type of stigma is being used to police both women's and men's behaviour and to conceal the unnaturalness of heterosexual gender norms. In changing the referent, people are presented with two realities: 1) that the signifiers "woman" and "man" may not have a straightforward connection to the bodies they refer to; and, 2) the signifiers attached to "mental illness" and "addiction" may, in fact, be working to make people believe that the connection between the signifiers "man" and "woman" have an inherent connection to the bodies that they refer to.

Yet as I discussed above, there may be ways to resist taking up the label of "mentally ill" and "addict" altogether. As previously mentioned, behaviours that are oftentimes responses to trauma, violence and loss are frequently classified and labelled as mental illness and/or addiction. Frequently, counsellors use the term "crazy-making behaviours" as behaviours used by children and adults to cope with traumatic events. Such behaviours may consist of: self-harm, such as cutting and addictions; and behaviours which may be classified as symptoms of depression, including sleeping too

much, isolating oneself, and keeping people at a distance. Anti-stigma campaigns that use a normalization approach, espousing the message that "People who have a mental illness are just like you and me," and "Mental illness is a biological disease," I would argue, don't actually get to the heart of the issue as oftentimes these behaviours are responses to trauma, violence and loss.

If the goal of an anti-stigma campaign is to encourage individuals who may be suffering in silence to come forward and seek appropriate care, (and NOT to come forward, get diagnosed with a mental illness, and get a prescription), it might be far more useful to address the issue of trauma and coping, and forego the label of mentally ill and/or addict. Messages might include, "I'm not mentally ill, I'm just trying to cope with the violence I've experienced throughout my life in the best way I can. But I'm ready to start making changes to the ways I cope and respond to the trauma I have experienced." The challenge would be that a large amount of funding for anti-stigma campaigns comes from pharmaceutical companies, which have a stake in encouraging individuals who are suffering to come forward, be diagnosed with a mental illness, and then be given the corresponding prescription medication. Yet the benefit would be that in taking away the labelling process and discussing the concept in terms of responses to trauma, the policing of heterosexual gender norms is unravelled ever so slightly, exposing some of the reasons why these labels have been created in the first place.

5.2 Response-Ability in Our Inter-Relationships

Trauma: Teaching People How to Respond to a Disclosure of Abuse

For individuals diagnosed with a mental illness and/or addiction, one must consider the strong correlation between responses to trauma and the labelling of these behaviours as mental illness and/or addiction. The disclosure to a loved one of having been diagnosed with a mental illness and/or addiction might be preceded by a disclosure of past experiences of physical, emotional, verbal and/or sexual violence. In this case, violence prevention organizations may be able to provide crucial insight and invaluable resources to family members and friends on how to prepare and respond to a disclosure of physical, emotional, verbal and/or sexual abuse. An example of recommendations on how to respond to a disclosure of experiences of violence includes:

- **Controlling one's reaction** — Being careful not to over or under react and being aware of your facial expressions, gestures and tone of voice;
- **Avoiding leading questions** — Sticking with more open-ended questions such as "Tell me about that";
- **Not passing judgment** — Communicating both through words and body language the message that "it is not your fault;"
- **Not correcting language — Let the individual tell her/his story in her/his own words. Oftentimes when a child is disclosing s/he may use the wrong or crude terminologies — a disclosure is not the time to be correcting language or teaching the proper words for body parts.**

- **Praising the individual for having the courage to tell** — Individuals who have experienced violence will often assume responsibility for the abuse, especially if the abuse occurred as children, as a child's mind may be incapable of processing it in any other way;
- **Protecting the individual from overexposure** — Respecting the individual's need for privacy and making sure her/his experience is only shared with others when absolutely necessary; and
- **Showing affection** — Often people are cautious about physically comforting an individual who has just disclosed an experience of sexual abuse, but research has shown that individuals, including children, who have disclosed abuse need comforting, support and understanding.

(Canadian Centre for Child Protection, revised 2010)

There are many misperceptions when it comes to disclosure of experiences of sexual, physical, emotional and/or verbal violence, especially if the abuse occurred when the individual was a child. Myths surrounding disclosure of child sexual abuse include: believing that a child would tell someone immediately after the abuse occurred; that a child would disclose if questioned directly; and, that disclosure of child sexual abuse is a one-time event. Yet research demonstrates the opposite — only 30 per cent of child sexual abuse victims disclose the abuse during childhood, often being afraid of a negative reaction from their parents or of being harmed by the abuser (Hon. Sydney Robins, 2000). Disclosures of sexual abuse often unfold gradually over time, and are not, as one might believe, a one-time event. Children, and even adults, may hint at what happened to

them without directly stating that they were sexually abused, to test the other person's reaction. This is where caring, supportive and understanding responses to disclosure are crucial.

Reaction to a disclosure of violence and abuse may be coloured by the stigma associated with mental illness. This may mean, among other things, that heterosexual gender norms that lie beneath the negative stereotypes. For example, a disclosure about being raped while out drinking at a bar from a young woman struggling with addiction issues may be met with judgment and criticism based on the stigmatizing belief that women who use substances are sexually promiscuous. Therefore, it is important to address these stigmatizing beliefs, but also it is important to arm people with information that will lead to more meaningful, healing disclosures not only for the individual disclosing but also the person responding to the disclosure. One may believe that one does not hold any of these stigmatizing views until being confronted with a disclosure and being asked to respond.

Oftentimes anti-stigma campaigns focus on the larger attitudes, behaviours and beliefs of individuals in targeted populations. An example of this would be how the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative is focusing on how to change the stigmatizing attitudes and behaviours espoused by youth and health care professionals. This does not, however, give more concrete information on how to handle a disclosure, which is, in essence, critical to the recovery of individuals who have been labelled as mentally ill and/or addicts. Since many of the behaviours classified as mental illness and/or addiction are responses to trauma, people must be prepared to

respond to both a disclosure of mental illness and/or addiction and of experiences of violence. The way in which a person responds to such a disclosure will greatly impact the recovery of the person disclosing. This is why anti-stigma campaigns need to address how to create safe environments where people feel comfortable in disclosing.

5.3 Response-Ability in Our Communities

The Sexualization of Girls and Women: The Production of Prohibited Identities

Power systems often produce identities they then prohibit in order to maintain the illusion of the stability of heterosexual gender categories. This was demonstrated in Chapter 4 in my discussion of the sexualization of girls and women in mainstream media and popular culture (i.e. the production of an identity), and its links to the stigmatizing labels used against girls and women living with addiction issues — that female addicts are "hypersexual," and "sexually promiscuous" (i.e. the prohibition of an identity). In doing so, both desire and what is defined as respectable femininity are policed in such a way as to conceal their constructedness. The stigma against girls and women diagnosed with substance dependencies feeds this construction by maintaining an appearance of stability in terms of heterosexual gender norms.

Part of beginning to change the systems of thought that stigmatize women who use substances as a way of responding to powerlessness and trauma, must also include inquiry into the rampant sexualization of girls and women in mainstream media and popular culture. They must also look into the impact of this sexualization upon girls', boys', women's and men's lives. The American Psychological Association writes that,

though there has been solid research done on the effects on women of having an objectified body image, research in the area of the impacts on girls is still in its infancy. However, though research projects such as the Canadian Centre for Child Protection's report on child sexualized modelling, which will be released later this year, are beginning to bring this type of inquiry into the forefront. The need to identify effective, culturally-competent protective factors, helping young girls develop a non-objectified model of normal healthy sexual development, through programs targeted at schools and other activities for youth is essential.

Multimedia educational materials that are not only age-appropriate and represent ethnically and culturally diverse young people, but also begin to deconstruct heterosexual gender norms, could be distributed to schools and community centres in order to begin to facilitate the discussion on how the sexualization of girls and women in mainstream media and popular culture affects everyone. An example of this might be online word matching games where students are asked to first match traits that have typically been identified as masculine or feminine with whatever gender category they choose, and after doing so, are asked a series of questions as to why they chose to match such traits to one gender or the other. Another example of this sort of work includes an app being created by PinkPom Digital in partnership with the National Film Board that will allow youth to take a photograph of an advertisement or sexualized image of a girl or woman with their cell phone and allow the youth, through their cell phone app, to alter the image, write over top of the image, and deconstruct the image. Of note, health promotion and

prevention research indicates that multimedia educational materials are only marginally effective unless used as one part of a more comprehensive initiative.

The Need to Address the Pathologization of Gender-Variant Identities

In Chapter 3, I examined how natural human diversity is often pathologized. Anti-stigma campaigns need to address how stigma against individuals diagnosed with a mental illness is being used to police heterosexual gender norms, with people who do not neatly fit into gender categories being falsely labelled as mentally ill, only to be further stigmatized. This has much larger implications in the way we label natural human diversity. Anti-stigma campaigns should partner with LGBTQ groups in order to advocate for the removal of these labels in the Diagnostic and Statistical Manual of Mental Disorders. If anti-stigma initiatives are truly advocating for recovery and healing, eliminating the trauma and violence of forcing healthy, happy individuals who identify as transgender to not only take up the label of mentally ill but also conform their stories and histories to meet the diagnosis in order to access sex-reassignment surgery, should be a priority.

Media

As discussed in Chapter 4, power and those who exercise power have the ability to create large-scale systems of thought which mainstream media often reflect. The Mental Health Commission of Canada, as part of their anti-stigma initiative, *Opening Minds*, has hosted a forum for budding journalists to tackle issues such as the use of

"appropriate language" when reporting on events involving individuals who have been diagnosed with a mental illness and/or addiction, and avoiding using negative stereotypes of such individuals.

Foucault believed that the role of educators was to help students develop the capacity to take traditional ideas and use them to think about their world differently, to advocate for change. When I was a journalism student, there was no questioning in classes of the construction of the concept of "objectivity," the cornerstone of journalistic inquiry. Frequently, educators, who were oftentimes successful journalists in their own right, were seen as having mastered a body of knowledge, the art of reporting, and were seen by students as having a degree of power and influence in society. Journalism students strove to skillfully manipulate the "who?" "what?" "when?" "where?" "why?" and "how?" of a story into something salient and "newsworthy." In doing so, they believed, they too, would have a degree of power and influence in society. Never were we taught to question how the decision of what made a story "newsworthy" came to be in the first place.

In order to make change in mainstream media, journalism students need to understand that their role is not merely to acquire knowledge in a passive way, but to use knowledge that they acquire to find ways to alter society for the better. Educators of journalism students need to encourage such students to begin to take traditional knowledge and to interpret and deconstruct it in their own way, not simply to mimic the actions of the educators. Teaching journalism students about language and the deconstruction of categories such as gender may encourage some future reporters to

question the way in which they give meaning to events. Discussing with reporters how the construction of worthy, grievable lives versus unworthy, ungrievable lives occurs through decisions they make such as who they give authority to in articles (i.e. who has a voice and is quoted in the article) and whose voice is absent in the article. This may also encourage journalists to give pause to their own contribution in the construction of stigmatized identities. Journalists must become more aware of their part in the construction of identities.

Law

When the federal government announced plans to create the Mental Health Commission of Canada, in the same budget announcement they outlined their tough-on-crime policies, which would, in fact, further criminalize individuals living with addiction and mental health issues. An anti-stigma campaign that works towards combating the stigma associated with mental illness and/or addiction cannot work if the ways in which individuals may respond to experiences of trauma, loss and violence are being criminalized and further stigmatized by the justice system. This requires asking tough questions about who makes up the prison population, and the identities being criminalized.

Anti-stigma initiatives must also look at ways in which the law at times upholds stigmatizing beliefs and attitudes, an example being the recent court ruling in Winnipeg, Manitoba mentioned in Chapter 4 of a man convicted of sexual assault who was given a two-year conditional sentence (meaning no jail time) because the judge found the victim

was sending the message that "sex was in the air" because she was intoxicated. Manitoba justice officials have filed an appeal of the judge's controversial ruling and the Canadian Judicial Council has received numerous complaints. This demonstrates how anti-stigma campaigns must work with women's anti-violence movements to combat the negative perception that the bodies of women who use substances are spaces where violence can be perpetrated with impunity.

Also, if anti-stigma initiatives proclaim that any stigma associated with mental illness and addiction will not be tolerated, then there needs to be appropriate mechanisms for people to report discrimination, whether it be in housing, employment opportunities, media reports, or any other form. In having a proper reporting mechanism in place, individuals who are labelled as mentally ill and/or addicts will be empowered with the ability to respond to discrimination and be heard.

Health Care Institutions

Stigma is one of the most common barriers to individuals diagnosed with a mental illness and/or addiction in accessing care. In Chapter 4 we discussed how pregnant and mothering women with substance-use problems are often perceived as "bad mothers," a label that impedes women living with addictions from accessing proper care. An anti-stigma campaign may want to consider creating posters for health care organizations, doctors' offices and hospitals, dispelling this negative stereotype and encouraging women to seek treatment. Right now, poster campaigns about substance-use and pregnancy, such

as those working to combat fetal alcohol syndrome, play into the bad mother stereotype by concentrating on the health of the child. In order to truly create change for women living with addictions, anti-stigma campaigns must address the way that the stigma of the "bad mother" is constructed based on heterosexual gender norms and is not an identity that a woman must take up in order to access appropriate addiction treatment. Messages such as, "We grieve in different ways, but if our coping mechanisms are hurting ourselves and our loved ones, it's time to find new ways to respond. You are not alone. You are not a bad parent." might help to deconstruct some of the stigma. The problem is that this message must be backed up by the attitudes of health care professionals, as well as access for pregnant women to harm reduction treatments.

As discussed in previous chapters, the role of trauma plays a large part in behaviours classified as mental illness and addiction. The disconnection between services for individuals who have experienced violence and mental health and addiction treatment services creates a gap that Canadians fall through every year. All to frequently women's shelters will not accept women who have been diagnosed with an addiction and/or mental illness. Addiction treatment services and mental health services oftentimes do not address the impact of trauma on an individual's mental health. Also, they often don't provide shelter for women and children leaving domestic violence situations. If one of the goals of an anti-stigma campaign is to have more people come forward to seek help, such an initiative must also look at the follow through, and whether when an individual comes forward to seek access to help, that the appropriate systems of care are in place for a meaningful recovery.

5.4 Conclusion

Real opportunities for recovery and healing from trauma and loss do exist. I know this very well, speaking from personal experience. It is about re-envisioning response, including how we respond to individuals who have become undone, and become the loss that they have experienced. In labelling and categorizing these responses in such a way that helps to police and restrain heterosexual gender norms, we are missing the bigger picture. In stigmatizing individuals who are labelled as mentally ill and/or addicts in such a way that helps to, again, police and restrain heterosexual gender norms, we are re-victimizing, and re-traumatizing. If we are to truly begin to work towards combating the stigma associated with mental illness and addiction, we must first begin to question how, as a community, we respond to loss.

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