

CANADIAN JOURNAL OF

Disability Studies

Published by the Canadian Disability Studies Association · Association Canadienne des Études sur l'Incapacité

Canadian Journal of Disability Studies

**Published by the Canadian Disability Studies Association
Association Canadienne des Études sur le Handicap**

Hosted by The University of Waterloo

www.cjds.uwaterloo.ca

cjdseditor@uwaterloo.ca

**This document has been made accessible and PDF/UA compliant by Accessibil-IT Inc.
For more information go to
<http://www.accessibilit.com>**



Failure to Comply: Madness and/as Testimony

Clementine Morrigan
York University

Abstract

Self-harm, suicide attempts, disordered eating, addiction, and other forms of “acting out” are associated with the trauma of surviving violence. While these behaviours are pathologized as symptoms of mental illness, they can be understood, instead, as strategies of resistance against violence. When violence is ignored or normalized, the “acting out” associated with trauma can be a means of sounding an alarm that something is very wrong. This “acting out” can be understood as an embodied form of testimony. When direct resistance to violence, such as fighting back or escaping, is thwarted or impossible, traumatic “acting out” can be a way to draw attention to and resist violence. Psychiatry, instead of answering the call of trauma by addressing the underlying violence, works to silence that call. Through incarceration, sexual violence, enforced isolation, restricted motion, threats, coercive drugging, gaslighting, and other abusive tactics, psychiatry works to undermine the embodied testimony of trauma by producing compliance. The source of the problem is shifted from the original violence and located instead in the body of the traumatized person. Successful treatment is understood as the reduction or elimination of the very “symptoms” which are in reality acts of resistance to violence. Therefore, successful treatment essentially means submission. The carceral space of psychiatry continues the work of producing compliance even after the patient has left its enclosures, extending the space of the psych ward into the everyday lives of psychiatric survivors.

Keywords

Psychiatric industrial complex, psychiatric incarceration, trauma, personal narrative

Failure to Comply: Madness and/as Testimony

Clementine Morrigan
York University

Content Warning

Psychiatric incarceration, incestuous childhood sexual abuse, suicide, addiction/alcoholism, police, description of self-injury, description of overdosing, description of sexual abuse, description of drinking.

Introduction

Self-harm, suicide attempts, disordered eating, addiction, and other forms of “acting out” are associated with the trauma of surviving violence. While these behaviours are pathologized as symptoms of mental illness, they can be understood, instead, as strategies of resistance against violence. When violence is ignored or normalized, the “acting out” associated with trauma can be a means of sounding an alarm that something is very wrong. This “acting out” can be understood as an embodied form of testimony. When direct resistance to violence, such as fighting back or escaping, is thwarted or impossible, traumatic “acting out” can be a way to draw attention to and resist violence. Psychiatry, instead of answering the call of trauma by addressing the underlying violence, works to silence that call. Through incarceration, sexual violence, enforced isolation, restricted motion, threats, coercive drugging, gaslighting, and other abusive tactics, psychiatry works to undermine the embodied testimony of trauma by producing compliance. The source of the problem is shifted from the original violence and located instead in the body of the traumatized person. Successful treatment is understood as the reduction or elimination of the very “symptoms” which are in reality acts of resistance to violence. Therefore,

successful treatment essentially means submission. The carceral space of psychiatry continues the work of producing compliance even after the patient has left its enclosures, extending the space of the psych ward into the everyday lives of psychiatric survivors.

I make these arguments largely based on my lived experience as a psychiatric survivor. This article makes the methodological move of mapping Madness in its encounters with incarceration and choosing to centre my own, firsthand, embodied accounts of psychiatrization. Joining a long history of psychiatric survivor testimony, I offer my experiences as a call to action against the institutionalized violence of psychiatry. Mark Cresswell (2005), while tracing the history of psychiatric and self-harm survivor self-advocacy and testimony in the UK, writes “[i]f self-advocacy is the form that survivor-activism takes, then “direct experience” is the well of knowledge from which it draws” (p. 1671). I draw from the well of my lived experience with Madness and psychiatry in order to invoke in the reader the sense of violation that I have lived. Cresswell reminds us that the impact of psychiatric survivor testimony is “affective, but also visceral and not just cognitive; it is not the same as... the presentation of third person vignettes” (p. 1674). I offer my firsthand, embodied experiences in the hopes of invoking an affective, visceral response. Ultimately, I hope that this affective, visceral telling produces within the reader a call to action. Cresswell writes, “testimony aims to bring into being a state of affairs in which the survivor’s truth is witnessed as an event about which ‘something ought to be done’” (p. 1672). In writing this testimony, I join a rich history of psychiatric survivors and Mad-identified people who collectively draw on the well of our lived experiences in order to draw attention to realities about which something ought to be done.

Shaindl Diamond (2013), in a critical ethnography of Toronto’s overlapping communities of psychiatrized people, discerns three ideological frameworks present in these communities.

Diamond calls these frameworks “constituencies” and names them the psychiatric survivor constituency, the Mad constituency, and the antipsychiatry constituency. While these constituencies are by no means discrete or exhaustive of the approaches within psychiatrized communities, Diamond’s analysis offers important tools for thinking through the activism and community building of psychiatrized people. According to Diamond, the psychiatric survivor constituency focuses on the violence of psychiatry, drawing on the testimony of psychiatric survivors and offering peer-led community support. The Mad constituency focuses on Mad identity, remaining critical of psychiatry but shifting the focus from psychiatry onto Mad people themselves. The antipsychiatry constituency draws on the lived experience of psychiatric survivors, but also includes the perspectives of academics and professionals who are not psychiatric survivors, with the aim of abolishing psychiatry entirely.

Diamond offers important suggestions for building community and solidarity among these overlapping and divergent perspectives. Each of these constituencies draws on psychiatric survivor testimony as a strategy in varying ways. The psychiatric survivor constituency relies on survivor testimony most exclusively and frequently, the Mad constituency uses survivor testimony but also employs narratives of Madness, and the antipsychiatry constituency draws on survivor testimony as well as analysis by non-survivors. While I have affinities with each of these frameworks, I locate myself and this work within the psychiatric survivor framework. I am most interested in producing testimony that reveals the violence of psychiatry and functions as a call to action toward a more just world.

Along with functioning as a call to action, psychiatric survivor testimony can function as a form of solidarity and community building. It can be the whisper that says, “it happened to me too.” I first came to stories of Madness and surviving psychiatry through zines. These were zines

that talked about surviving incest, self-harm, and getting locked up. I don't remember the names or authors of the zines I came across in my teenage years, but I remember their message. I didn't need to be convinced of the reality of the violence that these writers faced, but their words helped convince me of the reality of the violence that I faced. I no longer felt completely alone. I had the company of strangers who confirmed for me that I was not crazy to believe that what happened to me was wrong. I started writing zines myself, and while this article situates itself within Mad studies scholarship, it ultimately draws on a lineage with its roots outside the academy. I write for the psychiatric survivors who were brave enough to tell their stories and for those who are just beginning to find words for what happened or is happening. In her memoir *Dirty River*, long-time zinester, poet, and author Leah Lakshmi Piepzna-Samarasinha (2015) writes about discovering the Mad movement through zines and then finding psychiatric survivor community in Toronto. She writes:

I hadn't been drugged or shocked or locked up, but I lived my life constantly worried that I would be. I just hadn't been caught yet. I was like the others, even if I wasn't in the psych hospital. The protests were important. But what was even more important was the compassion. Just the room to be crazy. (p. 150)

Psychiatric survivor testimony creates room to be crazy. It opens up space in which other survivors might dare to speak. It offers witness and validation by declaring that this violence happened to me too. Psychiatric survivor testimony is a powerful claim to the truth in the face of a silencing violence. I offer this article as another voice in this lineage of survivor stories.

Self-harm and other forms of "acting out" associated with trauma function as a form of testimony in and of themselves. Psychiatric survivors use testimony, written or spoken accounts of lived experience with psychiatry, in order to draw attention to and to resist the

institutionalized violence of psychiatry. Testimony contests the hegemony of psychiatry by offering survivor knowledges as alternative claims to truth (Cresswell, 2005). This strategy within Mad movements echoes the strategy of self-harm and other forms of “acting out” associated with trauma: both function as testimony and alternative claims to truth. While I grew up experiencing sexual abuse, the dominant narrative within my family was that nothing unusual or violent was going on. My cutting functioned as testimony to the reality of the violence that I experienced. It was a claim to the truth. Psychiatry worked to silence this testimony and its implicit call to action. The violence that I experienced was not addressed but the “symptom” of my cutting was silenced through coercion. By joining with other psychiatric survivors in the strategy of testimony, I reclaim the meaning of my self-harm, restoring it to its original function of testimony in and of itself. The resonance between self-harm and testimony as strategies highlights the importance of acting as witnesses and responding when we are called to action.

A Note on Positionality

I am a white settler from a mixed class background, a queer, assigned female at birth, non-binary femme and a survivor of childhood sexual abuse. These experiences and social locations impact and shape my experiences of trauma, Madness, psychiatrization, and incarceration. Being a white settler from a mixed class background means that my behaviours have been psychiatrized rather than criminalized. It is important to acknowledge that experiences with trauma or Madness by racialized people frequently end in violence, including murder, at the hands of the police. Andrew Loku and Sammy Yatim are two recent, examples from Toronto of racialized people who lost their lives to police violence for behaving in ways deemed erratic, unstable, or dangerous. My experiences are not the only experiences and I should not be

understood as speaking on behalf of all traumatized, psychiatrized, Mad, or disabled people. Instead, I offer these embodied accounts as important interventions into academic literature on psychiatrized people in which we are talked about rather than listened to. I am adding my voice to a history of Mad resistance against psychiatry. My hope is that this work will function as an invitation to other traumatized, psychiatrized, Mad, and disabled people to bring their firsthand, embodied knowledges into these conversations.

A Note on Language

Language is fluid and meanings are contested. Some of the terminology that I am using in this article is taken up in different ways by different thinkers. In the interest of clarity, I will offer an explanation of how I am using some of these terms.

Psychiatry: for simplicity's sake, I use the term psychiatry to refer to all institutions and knowledge systems which define, control, monitor, incarcerate, diagnose, medicate, or otherwise exert power over people understood as living with mental illness. Diamond (2013) reminds us that "many...professions including psychology, social work, and nursing...are in many ways complicit in maintaining psychiatric hegemony" (p. 76). I am using psychiatry as a catchall category to refer to all such professions, institutions, and knowledge systems.

Psychiatric Survivor: I am using this term to denote someone who has experienced violent, harmful, and/or nonconsensual psychiatric interventions. Cresswell (2005) writes: "in 1986, activists within the psychiatric field for the first time began to refer to themselves not as "patients", or "ex-patients", but *survivors*" (p. 1669). This term is meant to draw attention to the violence of psychiatry.

Mad: I use the term Mad to refer to people who self-identify as Mad because of experiences of psychiatrization and/or because of non-normative mental/emotional experiences. The term Mad comes out of a history of reclaiming and revaluing embodied experiences of difference.

Violence: I use *violence* as an umbrella term for all forms of harm enacted against a person or group including physical, sexual, and emotional violence, systemic oppression, incarceration, and forced or coercive medication or medical procedures.

Trauma: Bessel A. van der Kolk and Alexander C. McFarlane (2012) define post-traumatic stress disorder as “people’s inability to come to terms with real experiences that have overwhelmed their capacity to cope” (p. 488). I choose not to use the term post-traumatic stress disorder because not everyone consents to or has access to psychiatric diagnoses. Instead, I choose to use the term trauma to refer to the lasting emotional, mental, and physical effects of experiences that have overwhelmed the capacity to cope, especially the experience of surviving violence. Trauma is a complex and contested term. I use it because I need a word to describe the ongoing, lived effects of having survived violence.

Episode: I use the term episode to refer to mental or emotional experiences of heightened intensity that differ from a person’s usual state.

Self-Harm and/as Testimony

I have been feeling more and more like I don’t exist. There is this strange sensation that I have dematerialized. There is the rising of unbearable pressure, something worse than melancholy and far more urgent. I have been having breakdowns at school. Falling down in the middle of the hallway, pulling at my

hair, wrapping my body up into a ball. It feels like something must be done but I don't know what. Today I took all the Tylenol that was left in the bottle. I know it wasn't enough to die but I feel stoned and sick. I wander the halls telling people I have a headache and asking if they have anything I can take. I manage to get more pills this way. By lunch I've realized this might have been a bad idea so I eat something hoping it will absorb the poison of overdose. At last period I ask my friend if she will skip class with me. She says she has to go to class. We separate and I continue to wander the halls. Later, I find her leaving the school with her boyfriend. Something snaps in me. The building pressure has risen past the point of containment, even the sick haze of overdose can't keep it at bay. I move quickly, urgently, the certainty of my actions suddenly, automatically clear. I reach into a recycling bin, find a clear glass bottle, leave the school in a rush, cross the parking lot. I can hear my friend calling my name but she is in another world, a world I don't belong to. At the other side of the parking lot I kneel and smash the bottle. I collect the shards in the palm of my hand. I leave the school property and walk several blocks before stopping somewhere at the side of the road. There is a large truck parked there, the shadow of which offers me enough privacy. On the grass, I select a shard and take it to the skin on the inside of my arm. I find a way to make the cut; the blood releases. As quickly as I can, in desperate need of this relief, I slash my arms over and over again. Time has stopped. Everything has stopped. All there is, is glass and blood and pain.

When I was 15 years old, I began cutting myself, overdosing on pills, and having episodes in the middle of my high school. The above vignette illustrates one such episode, one

that ended up having a profound impact on the course of my life. There were many such episodes. There was also the visible crisscrossing of scabbed over cuts covering the surface of my arms. I hid my cuts at home but I allowed them to be visible at school. Some students approached the staff about this, and I was made to see the school social worker. During one of our sessions, I mentioned my stress over having to visit my grandparents because my grandfather made sexual comments about the children in my family and had forcibly made out with me when I was 12. I relayed this information casually. I did not understand this to be “my problem,” the reason I was cutting and overdosing, or even a big deal. My family made it clear that my grandfather’s behaviour was acceptable and normal, and that if I resisted I was rude and ungrateful. So I was shocked when the social worker called Children’s Aid and the police. This didn’t end the abuse in my life, but it did mean that I never had to see my grandfather again.

To most people the overdosing, the cutting, and the episodes that I was having at school appeared to be spontaneous, erratic behaviour. Those who had sympathy for me understood me as sick and in need of help. Those who did not understood me as selfish, irresponsible, and attention-seeking. My embodied experience of my behaviour, as expressed in the above vignette, was not linked to the abuse. I understood my behaviour as a pressing, urgent reaction to extreme physical and emotional discomfort. As someone who was experiencing ongoing sexual abuse and who was being told that nothing out of the ordinary was actually happening, my traumatic “acting out” was a means of making visible the violence that I was experiencing. Though I was not consciously aware of my reasoning, my self-harm functioned as a strategy of resistance. My cuts produced an alternate claim to truth from that of my parents. My cuts declared visibly that something was very wrong and bore witness to “an event about which ‘something ought to be

done” (Cresswell, 2005, p. 1672). In this case, my strategy of resistance was successful in that my self-harm directly resulted in me never having to see an adult who was abusing me again.

Despite the obvious reasons for my distress, my traumatic “acting out” was psychiatrized and eventually resulted in my incarceration in a psychiatric institution. Instead of acknowledgement that my behaviour was in fact an effective strategy against violence, my “acting out” was responded to with further violence. Instead of receiving the support and care that I needed to recover from the trauma of sexual abuse, I was treated as a problem in need of a solution. The location of the problem was shifted from the adults who abused and neglected me to my own body as a chemically imbalanced site of disorder. Erick Fabris and Katie Aubrecht (2014) explain that “[p]sychiatric prescriptions make it possible to define social suffering and dissent as signs or symptoms of the existence of personal disorder and moral weakness, rather than embodied responses to inequitable social systems” (p. 187). My suffering and my dissent were used against me as signs of sickness. Given the lack of power that I had as a child experiencing abuse from my caregivers, I am struck by my resourcefulness in communicating my suffering and dissent. Having no means to protect myself or to escape my situation, my traumatic “acting out” was an effective strategy for calling attention to and resisting the violence that was happening to me. Yet, this very resourcefulness was deemed the problem and used to justify further violence.

The psychiatric response to self-harm is to put an end to it, resorting to incarceration and forced medication if necessary. This is a refusal to answer the call of the testimony that self-harm offers. Instead of responding to self-harm with compassion and concern, psychiatry works to silence those who self-injure. By the time I resorted to cutting myself, I had already experienced years of sexual abuse that was ignored or facilitated by the adults in my life. I had disclosed the

sexual assault to my parents and to other adults to no avail. I was forced to accept my parents' version of reality, which presented the sexual abuse as normal and acceptable. Yet I could not accept this version of reality because I lived in utter terror. Self-harm gave voice to my violation. The unbearable pressure of living the unlivable was relieved as my body bore witness to the reality of the violence that I was subjected to. As Cresswell (2005) writes:

A growing number of *women* are choosing to call themselves “survivors” because they are *driven to self harm* by a society that *violates them as children and adults, ignores their personal experiences*, then compounds the violation within an ostensibly *helping system that actually harms them* (p. 1675, emphasis in original).

I was driven to self-harm as a last resort against the violence that I was experiencing. My self-harm was then used to justify my incarceration. The day that I took a glass bottle out of the recycling bin and cut my arms on the side of the road was the day that landed me in a locked psychiatric unit for the first time. My behaviour told a story of a child who was enduring something terrible. Yet the response was to treat me as mentally ill, to take away my freedom, and to silence the testimony of my self-harm through coercion and force.

Psychiatry and/as Sexual Violence

After the trip to the emergency room and the drinking of liquid charcoal, I am told that this episode represents a major departure from anything I have done before.

The hospital has made a referral to a locked psychiatric unit in downtown Toronto. The following day my parents drive me from my hometown. Upon arriving at the Youthdale Secure Treatment Centre I am separated from my

parents. After answering a series of questions I am led into a small room with a shower. I am handed two small paper cups. The woman staff member I have just met explains that one has shampoo and the other has soap. I am told to undress and to place my clothing and glasses in a plastic bin. I am told to shower and wash my hair. I do so quickly as the woman waits outside the shower. I am told to step out of the shower. I stand there naked, soaking wet and unable to see because I don't have my glasses. The staff member looks me over, tells me to turn around and then looks me over some more. She hands me a tiny towel, a pair of oversized gray sweatpants and an oversized gray sweatshirt. She tells me to get dressed and to wait. She leaves with my clothes and glasses. I dry myself with the towel as best I can and put on the clothing. She returns and instructs me to follow her. I am disoriented without my glasses. My hair is dripping wet. I am wearing strange, wrong fitting clothing. I am in shock from being made, without warning or explanation, to present my naked 15-year-old body to another person for the first time since I was a young child. In this state, I am brought into the unit.

Arriving at the locked facility in Toronto was shocking in and of itself. I had no idea what to expect. Being immediately separated from my parents and ushered into the shower room with little explanation was overwhelming to say the least. I was utterly unprepared for the experience of being made to shower and stand naked in front of a stranger. The fact that I was already a survivor of sexual violence made this encounter particularly traumatizing. This violation was justified as being for my own protection. The need to survey my naked, wet body was framed as a search for objects that I might use to harm myself. Even then, I understood the act as an

invasion of my privacy and degradation of my personhood. I now understand this act as sexual violence.

In the book *Are Prisons Obsolete?* Angela Y. Davis (2011) quotes Amanda George: The acknowledgement that sexual assault does occur in institutions for people with intellectual disabilities, prisons, psychiatric hospitals, youth training centres and police stations, usually centres around the criminal acts of rape and sexual assault by individuals employed in those institutions. These offences, though they are rarely reported, are clearly understood as being ‘crimes’ for which the individual and not the state is responsible. At the same time as the state deplores ‘unlawful’ sexual assaults by its employees, it actually uses sexual assault as a means of control. ...prison and police officers are vested with the power and responsibility to do acts which, if done outside of work hours, would be crimes of sexual assault (p. 82).

Sexual violence is carried out routinely. It is not framed as violence but as procedure. My consent was not required. My history of sexual trauma was not considered. This traumatizing experience made clear to me that within the walls of the psychiatric hospital I had no power.

Sexual violence is a tool used to produce compliance. Being made to shower and stand naked while being inspected by a stranger, being made to wear wrong fitting clothing that was not my own, along with the confiscation of my glasses, worked together to strip me of my personhood, demean me, and disorient me. It compounded the existing sexual trauma that led to me ending up in the psychiatric hospital in the first place. This violence in no way contributed to my healing or wellness. Forcing a child who has survived sexual abuse to strip naked in front of a stranger was not done in the name of healing. Rather, it worked to re-traumatize me and to

remove my ability to resist. As Davis (2011) points out, this kind of violence functions as a “means of control” (p. 82): reducing me to a state of traumatization, taking personal clothing that would have reminded me of who I was, and taking away my glasses so that I was unable to see effectively, all worked to take away my power. This was done to me immediately upon arrival and before entering into the locked unit so that I entered the unit in a state of powerlessness.

The Youthdale Secure Treatment Centres’ website claims that their “goal is to help children express their feelings appropriately, understand the relationship between emotions, thoughts, and actions, and learn to control their harmful behaviour” (n.d., para. 3). Despite claiming to provide a “structured and safe therapeutic environment” (para. 4), the focus remains on the child’s “harmful behaviour” (para. 3). It is this “harmful behaviour” that I argue functions as testimony and resistance to violence. This “harmful behaviour” works to make visible suffering and dissent. My cutting was a desperate attempt to survive and draw attention to sexual violence. This was responded to by subjecting me to further sexual violence. The goal of the Youthdale Secure Treatment Centres, and psychiatry more generally, is not healing or wellness. Rather, despite the use of words like “safe” and “therapeutic,” words which my experience reveal to be untrue, the goal is clearly control. These words remain in their description along with their attempts to hide and soften the means through which they achieve that control, means which include sexual violence. I suggest that the “harmful behaviour” which requires control is not the self-harm of a traumatized child, but the routine use of sexual violence within psychiatry as a means to produce compliance.

Isolation and/as Immobilization

At meals they always seat us with patients most unlike ourselves. I am never permitted to sit near the other teenage girls. Talking, beyond the basics of passing the juice, is not permitted. Seating us with the people we are least likely to talk to is meant to help facilitate this. I share a small table with three young boys, all of them probably under thirteen years old. The boy sitting next to me, a lively, friendly child of maybe eight years old, announces that he doesn't like spaghetti and he doesn't want to eat it. This, a perfectly normal statement from a child his age, fills the room with tension. No one says anything. A staff member explains to him that he has to eat it, and if he doesn't, he won't get a snack before bed. The nighttime snacks of packaged cookies are, for most of us, a highly prized aspect of mainly silent, mostly unpleasant days. The boy is visibly upset. He begins to argue. He begins to cry. He begins to raise his voice. He is warned one more time and then he is taken away. Away to wherever they take patients when they do not behave, away to where the cries and screams abruptly stop, and they are not seen again for days.

Fabris and Aubrecht (2014) write, “[p]sychiatry’s premise of reordering or curing identity (the disorderly ‘mad’ body) leads to the apparent intent to immobilize it first, then to treat it” (p. 187). The authors explore the ways in which psychiatric drugs are used as a means of immobilizing patients. I learned quickly during my stay at Youthdale not to cry, argue, or “act out” in any way. I was never taken away like the boy in the above vignette, so I do not know from firsthand experience what happened when patients were taken away. But witnessing fellow patients being taken away for minor offenses, hearing the yelling abruptly end, not seeing these

patients for days, and witnessing their increased compliance upon return frightened me enough to act as a deterrent. My reduction in apparent symptoms during my stay in the unit was not due to an increase in mental health or capacity to handle my emotions; instead, my apparent improvement was coerced through fear.

Along with the threat of complete isolation as a tool to produce compliance was the isolation that I experienced even among the other patients. One evening I was watching television with the group, staring in silence at the screen's flashing images that I had no say in or control over. A teenage girl who had recently entered the unit, but whom I assumed from her behaviour had been there before, said something under her breath. She was staring blankly at the screen so I wasn't sure if she had actually said anything. I turned my head to her. She then whispered harshly for me not to look at her and I understood. She was trying to engage in secret communication by whispering inaudibly while demonstrating the body language of simply watching TV. While her courage stirred my need for human contact, my fear prevented me from engaging with her. More than anything, I wanted out and I knew that any disobedience would increase my time there. I was immobilized. My desire for human connection and communication was overridden by my fear. I was completely isolated even as I sat in a room with other patients.

Community is essential to healing. Community among Mad and psychiatrized people can be particularly empowering. I longed to connect with the other teenage girls in the unit. I wanted to ask them about their lives and tell them about mine. Yet we shared only quick glances. We were being monitored at all times and direct communication between us was not allowed. Not all psych wards are like this. When I hear stories from other psychiatric survivors who were locked up in units where patients were free to talk to each other, my skin prickles with jealousy. On the subject of isolation and community, Irit Shimrat (2013) writes:

Awful as it is to be locked up on a psych ward, at least we patients have each other. When I've been inside, I have always experienced a sense of belonging. Many of us were able and willing to listen to each other's stories with the patience, gentleness, humour, and empathy lacking in our keepers. Ironically, we got a real sense of community from—and were helped to regain our ability to function by—other 'sick' people. (p. 154)

Community is powerful. Encouraging community among Mad and psychiatrized people offers opportunities for healing, growth, and empowerment. Yet psychiatry takes a risk when it allows such community to flourish. This kind of community offers mad and psychiatrized people tools to resist becoming compliant. In the lockdown unit, I was denied even the simple pleasure of conversation, contributing to my willingness to submit to their demands in order to get out as fast as possible.

Coercion and Chemical Incarceration

The days in the locked unit are mainly quiet. The opportunity to speak with staff members about what brought me here is rare. On one such occasion, in a private room with a staff member, I am told that I have a chemical imbalance in my brain. I ask how they came to this conclusion. The staff member simply repeats that chemical imbalances are what cause behavior such as mine. I ask how she knows this. She evades answering the question, telling me that I am being difficult and uncooperative. I explain that I am concerned about unnecessarily being medicated. I explain that I haven't yet had a chance to discuss the reasons I am so unhappy. I explain that I worry about medication being overprescribed. She tells

me I am being paranoid. She tells me that successful completion of this program, and prompt release, is dependent on my cooperation.

Liat Ben-Moshe (2014) points out that psychiatrized people are framed as “not competent enough to refuse treatment” yet “ironically... people’s competency is rarely questioned when giving consent to treatment” (p. 262). Psychiatric medications were presented to me as positive, helpful, and necessary. My questions and critiques were dismissed, and framed as symptomatic of my mental illness through the use of words like “uncooperative” and “paranoid.” At the same time, my apparent inability to make rational decisions was never framed as an impediment to my ability to consent to medication, only as an impediment to my ability to refuse it.

These coercive tactics are examples of gaslighting, and they worked to secure my compliance. Psychiatry uses gaslighting techniques to undermine psychiatrized people’s faith in their ability to assess reality and make decisions for themselves. Kris Nelson (2014) describes gaslighting as “a tactic used to destabilize your understanding of reality, making you constantly doubt your own experiences” (para. 17). Gaslighting is frequently used by abusers to make their victims doubt that there is anything abusive happening. Gaslighting shifts attention away from the problematic behaviour of the abuser and onto the victim’s ability to perceive, understand and make rational decisions about what is happening. While much of the writing on gaslighting as a tactic of abuse focuses on its use within abusive intimate relationships, gaslighting also takes place within psychiatry. When my completely valid and rational suggestion that more time should be spent considering the reasons for my unhappiness (given the circumstance of sexual abuse) was dismissed as me being difficult and uncooperative, that is an example of gaslighting. When my legitimate concern about the over-prescription of medication was dismissed as paranoia, that is another example of gaslighting. If the goal was to promote healing and wellness,

questions and considerations about my own treatment would be welcomed. The use of gaslighting reveals that the goal of psychiatry/psychiatrized environments is not healing and wellness, but compliance.

These coercive practices were an attempt to implement what Fabris and Aubrecht (2014) refer to as chemical incarceration. They define chemical incarceration as “mandatory drugging of people considered mad or mentally ill but also anyone in an institution who is drugged without informed consent, with or without diagnosis” (p. 187). The dismissal of my concerns and the use of gaslighting and coercion do not amount to informed consent. Eventually, I agreed to begin taking psychiatric medication despite not wanting to and not believing it would help me. I did so in order to appear cooperative and compliant in the hope that it would result in early release. Not only was I physically incarcerated in that I was kept in an enclosed space and not allowed to leave, my body was further incarcerated by the introduction of unwanted chemicals intended to change my behaviour. I experienced this medication as a dulling of my senses and a diminishing of initiative and desire. The drugs felt to me like low-grade dissociation but in an ongoing way without any respite or release. It was as if the world became muted. The urgency that I had felt before which drove me to self-injury, overdose and other forms of traumatic “acting out” was gone. That urgency, however, was an embodied resistance to my oppressive circumstances. Without it, the unbearable became acceptable. Fabris and Aubrecht write: “The term chemical incarceration makes it possible to consider psychiatric drugging as a form of legitimized violence intended to restrain movement, remove agency, and deny self-determination” (p. 190). This was my experience. Psychiatry worked not only to produce a compliant patient, but also a compliant daughter who would no longer call attention to abuse.

Double Violation

At night, the day staff leave and the night staff arrive. At night, my glasses are taken from me and I lie on a rubber mattress with a too-thin blanket covering me in an empty room with a covered window. The night staff sit in the hallway while the patients sleep. Tonight, I am in incredible pain. I get migraines, brought on by stress, and tonight I am experiencing an awful one. I toss and turn and try to ignore the pain but it is unbearable. In tears, I leave the room and approach the night staff, a woman I do not know. I tell her that I am in so much pain and can't sleep. She takes me into the main space where my days are spent, which is frightening and ominous in the dark. The night doctor, an older man I do not know, looks over my chart as I sit before him desperate and helpless. He tells me that I have a history of overdosing and therefore he cannot offer me any pain medication. I plead with him for just one Tylenol. He closes my chart, telling me no. Instead he offers to massage my neck to relieve the tension. He retrieves a bottle from the shelf and squirts a lotion into his hands. To my horror, he begins to touch me, rubbing my shoulders and neck. I sit there in the dark while he does this, not wanting his hands on me, just wanting relief from the pain. After he is finished, the night staff leads me back to my room and I lie on the mattress, sick and in pain.

This memory is perhaps the most difficult to revisit. Being a multiply disabled person who is both traumatized/psychiatrized and also experiences chronic pain, this vignette reveals the way that being labelled "mentally ill" can be a means of denying a person the right to access healthcare that they need. While my concerns about psychiatric medication were dismissed and

my history of overdose was not considered reason to avoid prescribing me pills, my need for a single, supervised Tylenol in the midst of severe pain was denied. One Tylenol would not have resulted in an overdose, but the opportunity to “teach me a lesson” about my bad behaviour was more important than administering appropriate healthcare. Not only that, but in a state of pain-induced helplessness, in a dark room with strangers, I was subjected to physical touch that was nonconsensual and extremely unwanted. As a survivor of sexual abuse, this invasive touch from an older man in the context of the helplessness of both physical pain and incarceration was traumatic.

Syrus Ware, Joan Ruzsa, and Giselle Dias (2014) describe prison as “an oppressive, violent, dehumanizing environment that worsens existing disabilities and creates new ones” (p. 174). While the authors are writing about incarceration within prisons, psychiatric institutions can also be described as oppressive, violent, and dehumanizing. Psychiatric institutions similarly worsen existing disabilities and create new ones. The disabling effects of trauma are compounded by the violent and abusive treatment within psychiatric institutions. Rather than addressing the initial violence that produced the trauma and resulted in the traumatic “acting out,” psychiatry uses violence, coercion, and fear in order to produce compliance. While the short-term effect of this was that I took the medication they prescribed and stopped “acting out” for the time being, this apparent “recovery” was not sustainable. The original trauma had not been addressed; instead, it had been added to by experiences like the one described above. Upon release into the community I was not “cured.” I was more traumatized than ever. Despite attempts to further my incarceration by keeping me medicated, I stopped taking the pills. My traumatic “acting out” continued and escalated. However, I no longer believed that anyone could help me.

Even more than the traumatic experience of having to shower and stand naked in front of a stranger upon entering the psychiatric facility, this experience of being massaged in the dark by an older man deeply affected me. The helplessness of being in extreme pain, the fact that this man was older and therefore reminded me of my grandfather who sexually abused me, the fact that I was uncomfortable with any kind of physical touch, the darkness of the room, all of this combined to make this experience particularly traumatic. I told no one about it for years. It found a place in the half-thought thoughts that store the traumatic memories I find too unbearable to think of. This experience sums up what Cresswell (2005) describes as the “double violation” of psychiatry:

Self-harm survivor knowledge, to sum up, may be viewed as structured in terms of a perceived *double violation*. In violation #1, the survivor is survivor of the gendered trauma of childhood; in violation #2 the survivor is survivor of those medical models which are conventionally presented as treatments. (p. 1675, emphasis in original)

The hands of the doctor on my neck and shoulders echoed my grandfather’s hands. I was violated again.

Un/Marked Bodies

I left the unit medicated despite the fact that I did not want to be medicated. I learned that the quickest way to get out was to comply. I got out and shortly thereafter came off the meds and dropped out of high school. Years passed. I am now seventeen and extremely drunk. I am at a party and I don’t know the difference between coolers and hard liquor. I grab a twenty sixer of some kind of

liquor out of the hands of some teenager. I tip it back and drink. I hear the words “CHUG CHUG CHUG” and then blackness. My hand is up in the air holding a piece of glass, my arm is bleeding. My parents are holding me down against my will. I am struggling, screaming, biting. The police officer is riding with me in the ambulance. I wake up the next day remembering only pieces from the night before, still too drunk to understand the weight of them. I am in the psych ward, in an empty room, on a bed. A nurse comes in with a small paper cup and hands it to me. Inside is a pill. She tells me to take my medication. I tell her I am not on any medication. She becomes visibly irritated and tells me just to take it. I tell her again, emboldened by my drunkenness, that I am not on any medication. I demand to know what she is trying to give me. She tells me it is a starting dose of Effexor (an antidepressant).

Despite my best efforts to avoid psychiatry, I found myself locked up within two years of my release from Youthdale. This time I was only kept in the psych ward for a few days. During that time, I was kept alone in a room with just a bed in it. When I initially arrived, and was still very drunk, I was screaming that I didn’t belong there. I was also screaming about being sexually abused. As I sobered up I realized that I needed to act compliant, for I did not want to risk being incarcerated for an extended period of time. I attempted to pass off my behaviour as an unfortunate incident of drinking too much. Both my behaviour and my psychiatric history indicated otherwise. Again, my naming of the sexual violence that I had experienced was not addressed. Again, the problem was located in my body. Again, psychiatric medication was pushed upon me without regard for my consent. The nurse who attempted to coerce me into taking a starting dose of Effexor was the first person to speak to me the morning after my arrival.

A drunk person who has not yet had a sober conversation with a doctor cannot give informed consent to starting a new medication. I don't even think it is safe for a drunk person to take most psychiatric medication. However, the imperative to have me medicated was as strong in this psych ward as it was in Youthdale. Medicating me would be a way to extend the space of the psych ward beyond its walls. It would be another way, beyond fear of incarceration, to continue the compliance which incarceration attempts to produce. Fabris and Aubrecht point out that "[c]ontrary to the notion of safe and effective treatment, drugging is not 'less restrictive' than a cage because our very thoughts and feelings are compromised, restraining people physically, and diverting our will to escape" (2014, p. 196). Despite their attempts at coercion I managed to leave the ward un-medicated. I was as cooperative as possible, assuring the doctors that it had been a bad night of drinking that wouldn't happen again.

This vignette also highlights that when psychiatrized people are understood as dangerous, the police may be involved. This was the first time, but not the last, that my behaviour was framed as a threat not only to myself but to other people. A police escort accompanied me to the hospital indicating that I was understood as dangerous. My white privilege definitely contributed to my being brought to a psych ward rather than a police station, and to my not experiencing police violence or being charged. Appeals against psychiatric incarceration often highlight psychiatrized people who are not framed as violent, citing that it is unnecessary to lock up people who aren't dangerous. For example, Fabris and Aubrecht write "I was hauled into an emergency ward for acting 'strange' at work, which like most such experiences was not dangerous" (p. 189).

While it is important to acknowledge that many psychiatrized people are incarcerated for nonviolent behaviour, it is also important to consider whose violence results in incarceration and whose does not. The police officer who rode in the ambulance with me did not follow up on any

of the accusations of sexual abuse that I was drunkenly yelling about. I have been incarcerated multiple times for my behaviour. The white men in my family who were responsible for my abuse have not. I do not advocate for incarceration in any case as I find incarceration to be inherently harmful and oppressive, but I think it is important to consider which bodies experience incarceration and which bodies do not. It is also important to consider what kinds of incarceration various bodies experience. My white, femme, Mad body is marked as mentally ill but not criminal. My abusers' white, male bodies are not marked by the violence they enact.

The Extended Psych Ward/Failure to Comply

Many years have passed. Despite avoiding psychiatry to the best of my ability, I have been formed and detained a number of times. I have escaped from a hospital after waking up there, knowing that they would form me as soon as they discovered who I was. Despite being in so much pain, I do not trust psychiatry to help me. My teenage years and early twenties included multiple suicide attempts, persistent self-injury, perpetual re-traumatization and years of active alcoholism. I am now twenty-six. I have found non-psychiatric counselling and non-psychiatric addiction support. I am seven months sober and more stable than I have been for many years. I have not had a family doctor since childhood and I am at an intake appointment for a new family doctor. The doctor asks me questions about my family's medical history. She asks me questions about my medical history. I am honest with her about my past but explain the supports I have in place and that I am sober and stable. She stops typing on her computer and turns to face me. She tells me that with my history of concurrent disorders I will need to be medicated.

She tells me she will refer me to CAMH (the Centre for Addiction and Mental Health) where I can receive treatment for both my addiction issues and mood disorders. I tell her that won't be necessary. I explain that I am doing well and accessing support that is working for me. I just need a family doctor for things like cancer screenings and basic healthcare. She tells me I am only seven months sober and that there is no way I will remain sober if I don't get the proper treatment. I tell her I don't want to go to CAMH or be medicated, that the supports I have are working and I am confident that I will be able to remain sober. She gets up abruptly and starts to leave the room. I ask her where she is going. She tells me that she will not be my doctor because I am refusing to accept the help that I need.

This final vignette drives home the fact that the goal of psychiatry is not healing or wellness but compliance. When I arrived at the intake appointment with this doctor, I was expecting routine questions about my health. I did not expect that my psychiatric history would be used to deny me access to healthcare unless I consented to being medicated and re-psychiatrized, something that I definitely did not want. The doctor told me that I would not be able to maintain my sobriety. At the time of writing this article, I am 3.5 years sober and I have remained sober without going to CAMH and without being medicated. This vignette illustrates that the space of psychiatry extends beyond the enclosures of psych wards and institutions for psychiatrized people. Psychiatry continues the work of producing compliance. It does so through coerced and forced medication, gaslighting, refusal to provide services such as healthcare, and threat of further harm or re-incarceration. Psychiatric survivors continue to be coerced and controlled even after we have left the physical spaces of incarceration. We are not trusted to

make decisions about our health. We are not permitted to define our own reality. Psychiatric survivor testimonies such as this reclaim reality from the authority of psychiatry. By writing our stories, we refuse to comply.

Conclusion

The traumatic “acting out” of my teenage years and the first half of my 20s represented an embodied resistance to trauma. Self-injury, suicide attempts, alcoholism, and overdosing worked both to manage my overwhelming feelings and to make clear that something was very wrong. My childhood attempts to stop or escape abuse proved futile. My traumatic “acting out” worked as an alternate means of resistance and an embodied testimony to the reality of what I was experiencing. My self-injury resulted in my never having to see my sexually abusive grandfather again. My drunken behaviour, while resulting in regular re-traumatization, also functioned as an obvious sign that there was something very wrong that needed addressing. My suicide attempts were clear messages that my life was unbearably painful and that I needed help.

Instead of help, however, I received more violence. Psychiatry has, multiple times and through multiple means, attempted to silence the call of my traumatic “acting out.” Instead of helping me to get free from violence and to heal from its effects, psychiatry encouraged my continued silence. The goal was to produce a person too terrified, too exhausted, or too drugged to resist. I offer this article as testimony to what I have lived, hoping that it will be “witnessed as an event about which ‘something ought to be done’” (Cresswell, 2005, p. 1672). I join with the psychiatric survivors, Mad pride activists, writers, and zinesters who come before me, offering my story as one of many who have survived psychiatry. I offer myself as a witness for those who have stories yet to tell. I am a traumatized person who lives with the impacts of repetitive and

sustained violences, but I have found ways to honour my truth and protect myself. Psychiatry, despite its best efforts, has failed to make me comply.

References

- Ben-Moshe, L. (2014). Alternatives to (disability) incarceration. In L. Ben-Moshe, C. Chapman, & A. Carey (Eds.), *Disability incarcerated: Imprisonment and disability in the United States and Canada* (pp. 255-272). New York: Palgrave MacMillan.
- Cresswell, M. (2005). Psychiatric “survivors” and testimonies of self-harm. *Social Science & Medicine*, 61(8), 1668-1677.
- Davis, A. Y. (2011). *Are Prisons Obsolete?* New York: Seven Stories Press.
- Diamond, S. (2013). What makes us a community? In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader in Canadian Mad Studies* (pp. 64-78). Toronto: Canadian Scholar’s Press.
- Fabris, E., & Aubrecht, K. (2014). Chemical constraint: Experiences of psychiatric coercion, restraint, and detention as carceratory techniques. In L. Ben-Moshe, C. Chapman, & A. Carey (Eds.), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (pp. 185-200). New York: Palgrave MacMillan.
- Nelson, K. (2015, June 22). Gaslighting is a common victim-blaming abuse tactic – Here are 4 ways to recognize it in your life. *Everyday Feminism*. Retrieved from <http://everydayfeminism.com/2015/06/gaslighting-is-an-abuse-tactic/>
- Piepzna-Samarasinha, L. L. (2015). *Dirty River: A Queer Femme of Color Dreaming Her Way Home*. Vancouver: Arsenal Pulp Press.
- Shimrat, I. (2013). The tragic farce of “community mental healthcare.” In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader in Canadian mad Studies* (pp. 144-157). Toronto: Canadian Scholars Press.
- van der Kolk, B. A., & McFarlane, A. C. (2012). The black hole of trauma. In B. A. van der

Kolk, & A. C. McFarlane (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 3-23). New York: Guilford Press.

Ware, S., Ruzsa, J., & Dias, G. (2014). It can't be fixed because it's not broken: Racism and disability in the prison industrial complex. In L. Ben-Moshe, C. Chapman, & A. Carey (Eds.), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (pp. 163-184). New York: Palgrave MacMillan.

Youthdale Treatment Centres. (n.d.). *Secure treatment to help children in a safe environment*. Retrieved from http://youthdale.ca/en/crisis_services/secure_treatment_unit.php