

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 l'Incapacité

Hosted by The University of Waterloo

www.cjds.uwaterloo.ca

Storytelling beyond the psychiatric gaze: Resisting resilience and recovery narratives

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Abstract: This paper explores the politics of resilience and recovery narratives by bringing critical ethnography and auto-ethnographic methods to bear on my own experiences with storytelling distress in different contexts. Inviting people with lived experience to share their stories is now common practice in education, mental health, and broader community venues. Yet even when the intent of the stories shared are to offer systemic critique of mental health epistemes, it is difficult to hear such stories beyond the psychiatric gaze. I argue that individual storytelling practices now get processed through resiliency and recovery metanarratives that continue to position both the problem and its potential solution at the level of individual bodies. By offering an account of my own experiences of storytelling, I explore the limits, risks, and productive functions of this practice. This includes how such narratives, in accumulation, can reify conceptions of the resilient and recovered subject and thus help solidify mental health truth regimes.

Storytelling beyond the psychiatric gaze: Resisting resilience and recovery narratives

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Introduction

This paper explores the politics of resilience and recovery narratives in practice. Using the case study of my own storytelling activities, I show how socio-political critiques of mental health and social service systems are folded into resilience and recovery metanarratives that continue to position the locus of trouble, as well as the potential site for cure, at the level of individual bodies. Stories spoken by service users are now desirable commodities, encouraged and even expected to be shared across diverse settings. I show how such stories we speak are siphoned through larger metanarratives of resiliency and recovery. The issue here is not which stories we share, but rather with how they are listened to and deployed within prevailing mental health metanarratives and the systems that work within them. These systems of power now incorporate such narratives not as critiques, but as commodities to benefit organizational interests and solidify mental health truth regimes.

Resiliency has become an ubiquitous skill-set to be used by individuals to protect the integrity of one's wellbeing, but are also encouraged to be harnessed as a resource for those 'at risk' or experiencing 'mental illness' (Edward & Warelow, 2005). For example, positive psychology and their accompanying technologies, such as Cognitive Behavioural Therapy, invite subjects to gather their personal strength to bounce back from adversity (Padesky & Mooney, 2012). Resiliency places responsibility on individuals to activate and self-govern wellness, which complements neoliberal healthcare reform. Resiliency policy and practice models offer cost

saving measures for public health and social care systems by diverting patients out of formal medical systems and into self-help, positive thinking, and affective governances, while normalizing the uncertainties associated with global neoliberal capitalisms. Resiliency is thus “a technology of looking inward: rather than confronting austerity measures or other matters of social justice through political action, citizens are enjoined to look inward, gather their strengths, and be resilient” (Howell & Voronka, 2012, p. 4-5).

Scholars have pointed to the troubles that resilience and recovery models present when applied to those experiencing distress. Techniques drawn from resiliency models aim to build better citizens, to be instilled broadly across a wide range of subject positions to improve coping mechanisms in, for example, soldiers and their families (Howell, 2014), university students (Aubrecht, 2012), foster youth (Hass & Graydon, 2009), and health and social work professionals (Chan, Chan & Kee, 2013; Tosone, Bettmenn, Minami & Jaspersen, 2010). Kalathil et al (2011) note that within the psy disciplines, ‘resiliency’ has come to mean an individual character trait to be developed, trained, enhanced, and measured. While “work by black feminists and educationists have sought to address this problem by focusing on the roles critical social theory, communities, families, spirituality, and shared resources” play, resilience has largely been harnessed as a human science activated at the site of individual capacity (pp. 15-16).

Critical Disability and Mad Studies scholars have shown that theories of resiliency are imbricated with the now mainstream recovery model. The clinical recovery model in its current formation works to complement biomedical mental health interventions by encouraging hope, self-efficacy, self-determination, responsibility and indeed resiliency in clients, whereby “some can find cure, others ‘resume normalcy’ while still others can build meaningful lives while living

with mental illness” (Howell & Voronka, 2012, p. 4; see also Poole, 2011; McWade, 2016). Central to recovery and resiliency frameworks (and contrary to disability pride and justice praxis) is that disability is understood as implicitly undesirable adversity, to be overcome through self-management.

As a result of the adoption of recovery and resiliency models, ‘people with lived experience’ of denigrated experiences like distress, incarceration, drug use, sex work, migration, and homelessness are now invited to tell their ‘lived experience’ stories within systems that manage them. Such inclusion proports to value the experiential knowledge that we hold as assets which help others in similar positions. In the context of mental health systems, select service users and peer workers, as embodied models of recovery and resilience, are often invited to share their stories in public and intimate ways to promote “feelings of empathy, hope, optimism and empowerment” (Voronka, 2017, p. 336). Thus, the possibilities of service user inclusion as empowerment tactics are tethered to the discursive shifts that recovery and resilience models have made in mental health and social policy and practice.

The Politics of Storytelling

Storytelling is central to the process of making ourselves subjects. This is especially so for mad people, who often become knowable as mad through narrating our experiences of distress. As theorized by Razack, narratives are different from individual stories. Individuals may tell their intimate stories of distress, but narratives assemble such stories in ways that, amalgamated, contribute to broader metanarratives of us in the social realm, “separating the experience of individuals from the way in which their stories are assembled for our consumption” (Razack, 2004, p. 18).

It's important to stress that it is not my intent here to devalue first-hand accounts of disability, distress, difference, and difficulty. Rather, I am exploring how such stories, in their accumulation, contribute to both dominant and contesting narratives of who we are as subjects, communities, and nations. As a disability studies scholar I have often relied on using auto-ethnography to produce critical analysis, but I am also conscious what 'giving good story' can do, and how representing a 'coherent self' to an audience can work within sanist frameworks of meaning-making. Despite these pitfalls, however, stories can also be a way of "thinking in skin" (Brooks, 2008, p. 242), using subjugated or denigrated mad knowledge to disrupt what is understood as knowledge proper (see Foucault, 1980). Similarly, as re-interpreted through postmodern and poststructuralist theory, critical auto-ethnography and other reflexive practices can be used to redress the legacy of past positivist ethnographic practices (Jackson & Mazzei, 2009) and to insist that all ethnographic text "is dislogical rather than monological, partial rather than apparently total" (Ahmed, 2000, p. 63).

This article offers an account of how my own public storytelling came to hold multiple meanings as it was processed by different audiences and as it landed materially in different places. In effect, it offers a critical ethnography of my own auto-ethnography. What I scrutinize is not how we make sense of our individual experiences through storytelling, but rather the ways in which current understandings of madness as mental illness shape how we can tell such stories, how they are heard and interpreted, and, most importantly, how they are harnessed within wider narratives that, through psychocentric logics, define us as 'at risk', as problems to be solved (Rimke, 2016). By doing so, this work shows how the rules that govern storytelling can work to refute/reinforce (and likely both, simultaneously) current dominant understandings of madness.

Storytelling through the Psychiatric Gaze

Donaldson (2005) describes the psychiatric gaze as “a gaze broadly structured by concepts of psychiatry and clinical psychology, but not exclusive to professionals in the mental health field” (p. 32). While psychiatry has become the leading discipline holding expertise over madness, psy discipline modes for understanding and intervening on difference now penetrate all associated medical and social helping professions. And psychiatric knowledge has become a commonly held truth that informs our everyday interactions with one other, making it difficult to relate to the other outside of this psychiatric gaze. In much the same way, modern mental illness paradigms set the stage for the productive possibilities of storytelling. Because experiences of distress (and outcomes that have become tied to them, such as criminality, suicidality, homelessness) are currently largely interpreted through psy discipline ways of knowing (Rose, 1998; 2019), it becomes difficult to speak (and be heard) beyond such precursory scripts.

Within psy-influenced paradigms, service user storytelling and ‘contact-based education’ with people with mental health issues is currently endorsed as a best practice to solve the problem of stigma and discrimination (Bell et al, 2006). This promotes the idea that mental health service users are responsible for diminishing the discrimination they experience, by sharing our stories with others who may discriminate against us. In effect, to counter dehumanization, it becomes our job to share our stories in attempt to humanize ourselves. Storytelling is “frequently represented in benign, magnanimous, or positive terms in rationally-nuanced, master narratives” (Grant & Zeeman, 2012, p. 2). In what follows, I work to unsettle psychiatric representations of storytelling distress as having a purely positive function by elucidating some of its conditions, restrictions, and productive functions. This means attending to “the settings in which storytelling is expected, required, or disallowed, the conventions

adjudging what kinds of stories are considered intelligible or successful, and the rules governing how stories may be told, and when they may be interrupted or interrogated or ignored” (Polletta, 1998, p. 425).

Storytelling to produce justice is complex terrain. The claim that personal experience is political has been central to feminist, queer, racialized, disabled, transnational and other movements, and “cultural studies, anthropology, history and legal theory as well as sociology have emphasized narrative’s counterhegemonic, subversive, and liberatory possibilities” (Polletta, 1998, p. 424). However, critical reflections on the possibilities, limits, and conditions of storytelling have queried what is produced when we draw on stories to counteract dominant discourse. The practice of storytelling for activism within mental health social movement activism also has a long history (Church, 1995; Costa et al, 2012; Crossley, 2006; Morrison, 2005; Woods, Hart & Spandler, 2019). Storytelling is a prominent way in which we have worked to redress injustices caused by systems of power, as well to assert our lived experience as power, value, and knowledge. Fabris and Aubrecht (2014) note that “within westernized narrative schemas, stories of madness have played a central role in the telling and retelling of histories of colonialism and conflict, enlightenment, eugenics, industrialization and urbanization, and control” (p. 193).

As a result, critiquing the productive value of storytelling is a difficult thing to do. As Razack (1993) notes, we “shy away from critical reflection on the practices of those on the ‘good’ side. Ironically, our analytical and pedagogical tools seem to discourage internal critique by calling for respect for different voices with insufficient attention paid to the contexts of both the teller and the listener” (p. 65). She then goes on to recognize that “there are land mines strewn across the path whenever story-telling is used” (p. 56). Exploring not only the conditions

under which it is possible to perform these stories but also their performative value, she asks, how “will someone else take them and theorize from them? Will they serve to reassure everyone that Canada is diverse, full of folklore? Who will control how they are used? Will immigrant women tell a particular kind of story in a form that they do not control? Such dilemmas are evident whenever storytelling is used” (Razack, 1993, p. 56). These issues also arise when we attempt to storytell madness within the confines of mental illness discourses. The stories that we tell are always mediated by the epistemes that proceed us. As Rembis (2014) notes, “the narratives we construct determine our reality; they determine what we know to be true, and they have very real material consequences in our lives. They also define what constitutes ... what we think we know about mental illness” (p. 142). Thus,

Important critical analyses and critics of how such stories are used to perpetuate inequitable social relations can be found within Disability Studies (Price 2011) and Mad Studies (Costa et al. 2012). Geoffrey Reaume (2009) cautions that stories of madness, however prevalent, are rarely told from a mad perspective. When such stories are told, they tend to depict madness and mental illness as conditions that produce isolated individuals naturally at home in the shadows (Fabris & Aubrecht, 2014, p.193).

In our current mental health moment, what once were ‘forbidden narratives’ (see for example, Church, 1995; Grant, Biley & Walker, 2011), banished from public hearing and contained to case files, have recently been reconfigured through recovery and resiliency discourses as workable narratives to change, sustain, and even promote mental health logics. Service users as experts by experience now regularly share their stories within mental health complexes. We are also asked to share our stories in public venues, both with the media and to various organizational interests. These stories are turned into public narratives which help

position our mental health systems as following current ‘patient-centred care’ policy and ‘service-user driven’ practice models. As we speak, we appear as the material realization of organizational mandates for progressive, recovery-oriented services (Voronka, 2016). Further, mental health peer workers are expected to disclose stories of distress as part of their work role (Mancini, 2019). Our stories are used to treat and counsel clients, and we are also expected to share them with professionals, which verifies that we are ‘authentic’ peer workers. We make ourselves knowable, and build ourselves through the stories that we weave of our past, present, and possible future. But we learn through practice that the value of these stories in the mental health marketplace is conditional. We are rewarded for, and are encouraged to become experts at, producing ‘resilience and recovery narratives’ that work to build larger framings of us as redeemable subjects. And so as storytellers, we learn to mediate our stories so that they fit within wider resiliency/recovery narratives.

I’ve been (re)telling my story in a variety of ways, in different contexts, and for different reasons (sometimes well thought through, other times not). The possibility of using storytelling as a political tool to undercut psychiatric dominance became available to me through psychiatric survivor activism: “In the 1980’s and 1990’s, psychiatric survivors began to insist that their perspectives represented real knowledge of how the psy-complex worked, and that this knowledge must be taken seriously in public decision-making” (Costa et al, p.89). Hearing activist communities’ systemic critiques offered alternative ways in which I was able to understand myself and others. And so I began to tell my story too. This practice grew, and in the past twenty years I’ve tried to use my story in countless ways. Some minor moments in teaching, mental health advocacy, and peer work contexts when trying to interrupt conventional discourse and offer openings for other ways of knowing. Others larger: guest lectures (in both conventional

and critical classrooms), academic conferences, and presentations at both conventional mental health and broader social justice organizations. Results have been mixed, often dependent on context. This is because stories of lived experience are confined by the larger national, institutional, and organizational spaces in which they are heard. Furthermore, “stories are differently intelligible, salient, available, and authoritative depending on who tells them, when, and for what purpose, and in what institutional context” (Poletta, 1998, p. 425). Stories that work outside familiar mental health metanarratives can at best trouble the foundations on which systems of power are built, and at worst, be heard in ways that reinscribe dominant mental health logics.

In what follows, I share a presentation that I gave at centre which focuses on mental health and social inequities. I was invited to give this talk after sharing an account of my lived experience at a mental health conference. As is often when I speak in conventional settings, I felt my story, carefully mediated and despite my attempts to speak it otherwise, was interpreted as a recovery narrative. Given this, I hesitated to retell the same narrative, and asked if I could both present my narrative, and query what it produces. This was met with full support. I held control over my talk, and the reflections I made during that presentation help build this text. The opportunity to tell, but then also undercut my story to query the risks involved in hearing it was a novel opportunity. The centre and the audience it brought in were already critically engaged in understanding mental illness as a contested construct. This mattered, as it opened up unusual possibilities for being heard. This event made it clear to me that, in certain moments, storytelling can still be a means of producing resistant counternarratives to dominant discourse.

For this event, I intervened on the original story that had prompted my invitation to speak. I folded layers of theory and reflection meant to prevent a smooth consumption from the

audience, and to mark the limits of hearing stories like mine beyond recovery and resiliency discourses. I did this to make visible how stories are mediated by those that speak them, but also by those that hear them, and are shaped depending on the context in which they are given. There is no true story. I start here with the original “story” that I carefully mediated to be presentable to a conventional mental health audience, but still inviting them to hear it beyond the psychiatric gaze, and then critically trace what can be produced out of such speech acts.

The Origins Story

As mentioned, I am here to speak of my experiences of being a street kid, and of being psychiatrically diagnosed. People like me are often asked to tell our stories, for many good reasons, which include imparting experiential knowledge that would be inaccessible without us. Having said that, I am also always a bit wary about “telling a story” to people who might understand what I say along an individualist framework. When we listen to stories, we often want to frame them as isolated personal issues that arc along a progressive timeframe. We start with normalcy, interrupt with individual tragedy, mention hardships, mark interventions, until we get to a place of heroic overcoming and recovery. These story frameworks add cohesion to lives that are always far more complex. These are the plotlines that fairy tales follow. This is not the storyline that I can put forward to you today. There was no evil witch that led to my downfall, no seven dwarves that took me in and nursed me back to wellness. And certainly no prince charming who was waiting in the sidelines, patiently, helping me to overcome.

Rather, as I share a piece of my story with you here today, I want you, as partners in this narrative, to think about how this story must be understood as one that transcends a simple victims vs villains framework. That this is not an individual story about my overcoming, but

rather must be understood as a tale where bodies, as Disability Studies scholar Catherine Frazee (2009) puts it – “collide with the larger forces of power and structure and governing relations that constitute the stage upon which the characters, including ourselves, perform our parts.”

If life is stage, and this is theatre, then I ask that this story not be understood as mine only. Any actor will tell you that the biggest player in any production is the audience, and audience response. And with an audience filled with social workers, housing providers, mental health workers, psychiatric professionals, academics, family members and my fellow people with lived experiences – I ask you to think about yourselves through this narrative, how you are activated by my story, where you fit, who you become, how you are implicated, and how we can lend to this need to complicate “my story” as “ours” – something that we are all involved in, and that we share.

The picture I chose to frame this talk is one of my brother Michael and I. I chose this picture because we are both in movement, in consort, he a little ahead of me, as he always was, as my only and elder sibling. At the time that this picture was taken, I was 17 years old, living on welfare, and marginally more secure as I had been in years previous, which had me living on the streets and couch surfing my way through my early teens. My brother, almost 20, had recently been released after a 3 year incarceration in a forensic unit of a juvenile prison. He was living in a half-way house when this picture was taken. Struggling with rules, with fear, with conditions and confines, we both were. Hungry, angry, and stunned by marginality, diagnoses and social and mental health regulations. And trying to figure out how to breathe through it all.

Michael was what is understood as hard to house. Workers tried, we all tried, to get him to a place where he could stay. His housing ranged from forced institutionalizations to half-way houses to rooming houses to shelters to subsidized co-ops and back again. He was in and out, up

and down, on and off, back and forth. He was usually being kicked out, most times abandoned by services once he misbehaved.

Michael died at the age of 21, while living in a transitional house – making that yet again familiar transition from institution to waiting for permanent housing. When he died, the conditions in which he was housed were beyond substandard. I ask you to draw on your own imaginations and picture your worse-case living scenario – coupled with people constantly monitoring your behaviour, witnessing and assessing your every tick, and the stifling heat of abject poverty. So stifling and squeezed was his room that he had to tilt his bed up against the wall in order to be able to open his closet door. Space matters. It was little surprise to me that it was while in this room that he decided to stop trying to breathe. It nearly took my breath away as well.

My housing story is different from Michael's. While he spent his teenage years locked up, I spent mine hiding from confines – on the streets and then in mostly rooming houses. Again, I leave you to imagine what being a street kid was like, for me. And of course, here, to consider how my gender, whiteness and general aesthetic (read young angry doc martin wearing feminist) affected the ways in which I was interpreted and diagnosed by psychiatry. In the early 1990s I lived on monthly welfare cheques that have not increased in amount since then. It is impossible to live on under \$600/month, now, in Toronto, and remain both housed and fed. I count myself lucky, because I squeezed in my welfare time just before the Ontario Harris years, living on what was known as student welfare for 4 years, which allowed me to scramble from rooming house to high school to after-school outpatient appointments. Two months after I completed high school, student welfare was cut. Had I been born a few years later than I was, the Harris conservative

provincial chill would have forced me into workfare instead of allowed me an entry point into an education.

I would not be here with you all today.

Space, and social policy, matter.

A few months after my brother died, I landed a one-bedroom apartment in a rent subsidized building. I spent a decade – from 20 to 30 – in that modest but well savoured apartment, with my own bathroom, a handyman janitor, and most importantly the dead-bolt locked door whose keys I held. Over that decade I ebbed into periods where privacy, the freedom to be alone, and boundary-building were important → that transition from street life, where you are always seen, always engaging with public life, with stranger-dangers → to getting used to, and relishing, my privacy. I flowed into rest, into books, and eventually into university → with subsidized rent, I was able to live off of student loans and enter the culture shock of the University of Toronto. I ebbed into health struggles, which were much easier to familiarize myself and others with under the calm of home. I flowed into love, slowly into life, into things that are so hard to come to fruition when you don't have your basics down.

I ebbed into grad school, flowed into jobs – and finally, after 10 years of shelter provided by the safety of my subsidized apartment, was ready to let it go. I knew that someone else was desperately waiting for the opportunity that my modest and cheap apartment had given me.

In telling this story, I wanted to make sure that I put housing first. To show how my brother's treatment did not – he was over-serviced in many ways, underserved in many others – never given his own place to be unwell, to cover to recover, to uncover, to discover. I fell into a place where I was able to be – well, unwell – how I was. It took a long time for me – to shift my

rage, my sadness, my fear – into articulations that would no longer hurt me. I needed that time, and my housing helped.

Cut – and end scene

The Limits of Hearing

Here is what risks being reproduced from such hearing such stories. Presenting (what gets taken up as) ‘my personal story’ to any audience is a complicated process. Through my storying, I open my difference to others who inevitably attempt to master it and make it knowable. In particular, professionals regenerate themselves again and again as “the authentic knower while [I] remain what is to be known and consumed, and spit out again” (Razack, 2007, p. 379).

Through my narrative, an audience of helping professionals are enabled to reconstitute themselves as rational, compassionate citizens. As they hear me, my story gets transformed into their pleasure, reaffirming their morality and the humanity of the ‘strengths-based’ labours that they perform on the likes of me (Razack, 2007, p. 382). My particular story is inevitably understood through the gentler but still medical discourses of resiliency and recovery. After sharing stories like these, I’ve been referred to countless times as strong, as recovered, or on ‘the journey to recovery.’ I become blanketed by their desire, or even need, to see me as cured. In part, this is because it is hard to be comprehensible to them as academic if I am still mad.

However, they also want to understand me as recoverable because doing so constitutes them as human, their sane practices as successful, and their psy disciplines as a working science (Razack, 2007, p. 385). They need to see me as their version of a success story, to justify their own (often violent) interventions on madness. The idea of my recovery uplifts them because it makes them the heroes of my story. Understanding me as cured justifies a continued practice of often

problematic psychiatric and psy discipline-informed interventions. This is the danger of what my voice can produce.

I attempt to orient the listeners away from interpreting my story as one of monolithic individual tragedy-resilience-recovery, but I know that even my explicit references to the fact that this encounter is a co-production, in which my audience too have an active role, can't force them to consume my words in a more reflexive fashion. I worry, as Spivak insists we should, about what the utterance cannot say, as well as about how "the intellectual is complicit in the persistent constitution of Other as the Self's shadow" (Spivak, 1988, p. 280). Standing up there as a stranger, I have already been "produced as a category within knowledge, rather than coming into being in an absence of knowledge" (Ahmed, 2000, p. 55). We have already been co-constituted in this audience, fractured along the divides of "service user" and "not."

In classrooms, I am often approached afterwards by students who share with me their own experiences of distress. I have yet to learn how to attend to these disclosures in any meaningful way. In larger public venues, I am often exposed to a painful flurry of encounters. I am the stranger revealed. Hordes of unknown people come at me abruptly, believing themselves entitled to speak to me of me, and to intrude their systems of belief on me. There is panic in my pulse with each approach. I begin to try to make sense of them just as they have made sense of me. I categorize them. I imagine those that complement my oratory skills, who say 'you are very articulate' or 'I like that you grounded the problems as a social justice issue' to be a particular kind of empathic academic, peer, or perhaps artist. Those who use words like 'cry,' 'brave,' 'strong' might be helping professionals, and perhaps feminists. And then there are the people who say "I never would have known by looking at you." The man who identifies himself as a psychiatrist and informs me he can *tell me* by the way that I dissociate while speaking, by staring

up at the ceiling. The people who plainly demand to know what my diagnosis is: “What’s your diagnosis, anyway?” I line these people up as clinicians, psy discipline practitioners, scientists. I categorize and make sense of their ontologies by guessing their subject positions, just as they use my language to make sense of me, and themselves. These face-to-face encounters remind me that “in daily meetings with others, subjects are perpetually reconstituted: the work of identity formation is never over, but can be understood as the sliding across of subjects in their meetings with others” (Ahmed, 2000, p. 7). These encounters also affirm that, however hard I try to frame my political narrative as something other than a personal family tragedy of weakness, poverty, and mental illness, metanarratives of heroic overcoming through resilience and recovery strategies prevail. The conditions under which I am heard outweigh and overwhelm me.

Such encounters seem like dialogues, but my capacity to be recognized beyond the psychiatric gaze is limited, leaving me frustrated and vulnerable. As a service user, I must know, understand, and often work with/in dominant understandings of mental health/illness. To sustain myself in this work, I continue to simultaneously try to invite others to think beyond such binaries: to open up possibilities for others to think beyond mental health/illness. When, yet again, my invitation to recognize multiple ways of knowing fails, I experience this as epistemic violence. My counter-discourses become ‘minor knowledges’ either delegitimized or simply unheard (Leigghio, 2013, p. 124).

Spivak asserts that a condition of being subaltern is that you are not heard. Ahmed builds on Spivak’s work by arguing that “a testimonial ethics is not simply about speaking, but about the conditions of possibility of hearing” (Spivak as cited in Ahmed, 2000, p. 157). Or, “In other words, the question becomes not so much, ‘who speaks?’, but ‘who hears?’” (Ahmed, 2000, p. 61)? As a mad informant (and unlike subaltern subjects) I am heard, but conditionally. I offer my

narrative up for consumption hoping to be able to control the ways in which it is savoured and swallowed. I know, as hooks reminds us, that “the commodification of Otherness has been so successful because it is offered as a new delight, more intense, more satisfying than normal ways of doing and feeling” (hooks, 1992, p. 21). That eating the other involves the process of consumption: “one swallows, digests, farts and shits. One takes in, and lets out. The white consuming subject is invited to eat the other: to take it in, digest it, and shit out the waste” (Ahmed, 2000, p. 117). My story isn’t digested as a critique on the tyranny of sanism as embedded in imperialist white supremacist capitalist cis-heteropatriarchy. Rather, it remains a story of tragedy, resilience, and recovery. The madwoman can speak as the madwoman – but how else can she be heard? What are the conditions of my consumption, and the possibilities of hearing? How, in these moments of voicing, “can we encounter an Other in such a way, in a better way, that allows for something to give” (Ahmed, 2000, p.154)?

(Co)producing the Resilient & Recovered Subject

At times the stories I tell, despite my attempts at resistance, are interpreted as recovery narratives, proof of either my innate or learned resiliency. Because service user stories as diversity and inclusion practices are currently hot products in mental health assemblages, telling my story has led to a commodity of speaking opportunities, and I have learned, uncomfortably, that bringing my abject out pays. Yet when I moved to a space that was welcoming of critical analysis, I was able to shape my story to think critically about what risks lie in telling it.

What I hope this demonstrates is that the productive function of service user storytelling continues long after the moment of speaking. To tell a story is to travel through the discursive quagmires of resiliency and recovery. It is rarely possible to escape them. My lingering

unresolved questions include: what is being produced in these moments of listening? And further, how can we be heard without being consumed? We all have to eat. How is sanity regenerated in narratives like the ones that I have just performed? What, and who, is reconstituted in moments like these? Is this just “useless knowledge” for others to take pleasure in (Razack, 2007, p. 389)? How can we seek spots where voicing madness helps cut through dominant epistemes? How can psychiatry recognize its own complicity and move from pity and pathology and into responsibility? How can such narratives be heard so that they “move beyond the individualist account to a ‘collectivist account’” (Razack, 2007, p. 390)? And then, the most pressing of my ongoing conundrums: should I stop speaking stories entirely, or wait until the divides of in/sanity are disbanded altogether? I fear that we would have long to wait. Is such storytelling still necessary? Can it produce knowledge that might still help fracture the bifurcated in/sane categories in their current formations? Basically, as I do this – how does it help, and how does it hinder?

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