(De)pathologizing Discourse:
The Problematization of Trans and Gender-Nonconforming Mental Health in Ontario

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Abstract

The trans and gender-nonconforming (TGNC) community has a complex relationship with psychiatry. The need for access to transition-related medical services is complicated by an increasing amount of activism that refuses the pathologization of TGNC identities through the diagnosis of Gender Dysphoria and the rejection of the biomedical model of mental illness more broadly. TGNC activists have mobilized concepts from critical disability studies and Mad studies, namely the biomedical and social models of mental illness, to describe their aversion to, and proposals against pathologization. However, this binary relationship between the biomedical and social models is problematic, as it is increasingly evident that conceptualizing TGNC mental health within this binary does not account for the complex reality of the lives of trans and gender-nonconforming people who must navigate between fighting pathologization without sacrificing access to publicly funded transition-related medical procedures, counselling services, and disability benefits. Consequently, in this thesis, I seek to trouble the binary relationship between the biomedical and the social, pointing to the shortcomings of mainstream disability discourses within TGNC mental health policies and practices in Ontario, using Foucault's notion of biopower and Pamela Moss' perching model to trace both the consequences of, and alternatives to, these limiting conceptualizations.

For all those who feel invisible, hated, forgotten.
For the queer, the crazy, the mad.

You are loved.

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Introduction

What counts as an illness? Who gets to decide? These questions have been at the forefront of recent activism in Ontario within the trans and gender-nonconforming (TGNC) [1] community. In 2016, news surfaced about the controversial treatment of transgender youth at the Centre for Addiction and Mental Health (CAMH) in Toronto. Dr. Ken Zucker, head of the Gender Identity Clinic at CAMH, was promptly dismissed from his position after it surfaced that he had been practicing conversion therapy to steer youth away from "becoming transgender adults" (Anderssen 2016). In January 2017, an article published in *The Guardian* highlighted the TGNC community's fear surrounding Dr. Zucker's appearance in an upcoming film on trans children. The article highlights issues that many parents of trans children had with Dr. Zucker's approach relating to gender dysphoria and mental illness, with many arguing that his opposition to the affirmative approach wrongfully perpetuates the idea that transgender individuals are mentally disturbed (Ellis-Petersen 2017).

However, this highly publicized criticism of Dr. Zucker is but one small part of a larger debate questioning the role of medicine in the lives of trans and gender-nonconforming individuals. Dr. Zucker's medicalized approach to gender dysphoria, and the act of pathologizing trans identities provides a practical example of a theoretical debate within the existing literature on TGNC mental health. This literature mobilizes concepts from critical disability studies and Mad studies to illustrate different approaches to gender dysphoria. These concepts include the

[1] I use the term transgender and gender-nonconforming as opposed to trans or transgender alone to account for the varying different types of gender identities that may need to engage with the medical industry for what are referred to as "gender-confirming" surgeries or treatments. The use of the term gender-nonconforming, within the context of this thesis, is used as an umbrella term for folks who identify as non-binary, gender fluid, agender, etc., and should not be confused with the alternative use of gender-nonconformity used to describe cis queer people, including butch lesbians or feminine gay men. This form of gender-nonconformity is considered non-pathological, according to the American Psychiatric Association's official position of Gender Dysphoria (2016).

biomedical[2] and social models of disability and/or mental illness[3], just two of several different ways to conceptualize disability. Whereas the biomedical model of mental illness frames biochemical differences in the brain as disease (Engel 1977, 130), the social model argues that psychological distress is a social, rather than a biological problem, switching the focus from disability to *disablement*¸ the idea that social structures disable people with certain physical or cognitive impairments (Goodley 2014; Withers 2012)

While there are several different models of disability, including the biopsychosocial model and radical model, the biomedical and social models are the two dominant approaches to disability theory. Unsurprisingly, these two dominant discourses have been adopted into TGNC community-based and academic discourses, particularly surrounding the topic of Gender Dysphoria.

The American Psychiatric Association currently classifies Gender Dysphoria[4] as a psychiatric disorder within the Diagnostic and Statistical Manual of Mental Disorders (DSM). The disorder is frequently diagnosed in individuals who perceive a difference between "one's experienced/expressed gender and assigned gender" (American Psychiatric Association 2016), that includes "significant distress or problems functioning" (American Psychiatric Association 2016). This adherence to a biomedical model of mental illness when diagnosing Gender Dysphoria in gender diverse patients has trans activists and scholars criticizing the propriety of the biomedical model, likening Gender Dysphoria's inclusion in the DSM to the former inclusion of homosexuality as a mental disorder prior to 1973. The removal of homosexuality from the

[2] Some critical disability theorists use the term "medical model" (Withers 2012) instead of "biomedical model". I have chosen to adopt the former to emphasize the specific impact that biology has on definitions of illness, and to distinguish this approach from social forms of medicine (see Park 1970; Rosen 1974)
[3] The difference between models of disability and mental illness are indistinct. Some authors, such as Pilling (2012) seem to use them interchangeably, as I do in this thesis.
[4] Previously classified as Gender Identity Disorder in previous versions of the DSM (American Psychiatric Association 2017).

DSM was largely due to activism within the gay and lesbian community. In 1957, Evelyn Hooker published a crucial report stating that homosexual men did not exhibit the requirements needed to diagnose a psychopathology, as the men surveyed showed no signs of distress, disability, or disadvantage, all requirements of a psychiatric disorder, and all were satisfied with their sexual orientation (Lev 2006, 40). TGNC activists saw this development as grounds for removal Gender Dysphoria from the DSM, a parallel that remains central to the arguments of TGNC activists today (Pilling 2014, Drescher 2009).

Several scholars (Ault and Brzuzy 2009; J. Feldman et al. 2016; Pilling 2014) argue that the biomedical model of mental illness is harmful when applied to trans and gender-nonconforming people, as it conflates mental illness with the identity of being trans or gender-nonconforming, rather than as something that could be attributed to the consequences of living in a cisnormative society, transphobia, or from a factor completely unrelated to an individual's gender identity (Pilling 2014, ii). These alternative explanations for TGNC distress are not immune from pathologization however, as Pilling argues that these responses have also been pathologized through diagnosing TGNC patients with mental disorders such as anxiety, depression, or PTSD, which many TGNC people also reject (Pilling 2014, 109). This argument is congruent with a social model of mental illness, as the emotional distress is a result of an oppressive society and is argued to be viewed as a normal reaction to social stigma and minority stress (see Hendricks and Testa 2012; Kelleher 2009). Similar arguments have been deployed by anti-psychiatry feminists such as Jane Ussher, who has challenged the psychiatrization of "hysteria" in women, which she argues is a "pathologization of femininity" (Ussher 2013, 63). It is evident that queer and trans people have a strained relationship with psychiatry that becomes increasingly complicated when these diagnoses move away from general mental health issues

such as depression, anxiety, and suicidality (see Haas et al. 2010, Rutherford et al. 2012), and toward pathologization of TGNC identities in the form of Gender Dysphoria (GD).

However, despite this vehement opposition to the pathologization of Gender Dysphoria, there has not been a complete rejection of the biomedical model. For example, TGNC activists in North America have argued in favour of maintaining GD as a registered mental illness within the DSM, if only because without this medicalized definition, many trans and gender-nonconforming people would not be able to have access to desired medical services such as sex reassignment surgery or hormone therapy (Drescher 2010, 427). Without these medical definitions and diagnoses, individuals seeking surgery or hormone treatments would have no legitimate grounds for insurance claims that help break down socioeconomic barriers to such assistance (Drescher 2010, 427). For example, in Ontario, individuals seeking sex reassignment surgery funded by the Ontario Health Insurance Plan (OHIP) must first meet the diagnostic criteria of Gender Dysphoria as defined by the World Professional Association for Transgender Health (WPATH) before they can even be put on a waiting list for the procedure (Ontario Ministry of Health and Long-Term Care 2016).

Alternatives to this tedious and patronizing reality have been proposed by both TGNC people and activist psychiatrists, who call for the elimination of Gender Dysphoria in favour of an informed consent model that would allow individuals to access transition-related services without an "in-depth mental health evaluation and referral" (Deutsch 2012, 140). Ideally, TGNC mental health policy will move towards a model of informed consent to best accommodate the needs and desires of TGNC individuals while respecting their autonomy[5]. However, informed

[5] It should be noted, however, that informed consent still requires that TGNC individuals attend one appointment with a counsellor to determine that they are mentally capable of understanding their decision and the risks and benefits associated with medically transitioning (Schultz 2006, 82)

consent has been met with resistance from health care providers fearing legal consequences from patients who later regret transitioning, despite overwhelmingly high rates of self-reported satisfaction, post-transition from TGNC people (Schultz 2006, 84). An informed consent approach to TGNC health care is also unlikely to be recognized as a legitimate health care problem, lacking the required legitimacy to justify health insurance coverage to fund transition-related surgeries and therapies (Schulz 2018, 87). While it is important to continue advocating for informed consent models, these barriers suggest that such a change may not occur expeditiously. In the interim, it is important that we focus on how to navigate health care systems as they are currently structured to help TGNC people manage their mental health in the present so that they may be alive to experience the changes of the future. To help TGNC people navigate the current mental health care system, and to better inform the decision-making processes of policymakers, I explore the following research questions: First, how is mental health framed in institutional policies and practices in Ontario that govern TGNC mental health and/or Gender Dysphoria? Second, what type of subjects do these policies and practices create? Third, how might we challenge the medical/social model dichotomy regarding gender dysphoria and TGNC adults?

In response to these questions, I argue that most mental health policies and practices in Ontario are not firmly situated within a singular discursive approach to mental health; many adopt language attributable to both medical and social approaches. While it should be expected that policy-makers the adopt a multi-pronged approach to social problems, these discursive inconsistencies raise questions as to how TGNC people navigate mental health care systems.

Second, I argue that the multiplicity of mental health policy discourses creates numerous TGNC subjects, who are often simultaneously framed as both sick and not sick, but often still

"unwell". This contradictory phenomenon occurs within policies that have seemingly attempted to shift their language towards a more social approach, but which fail to fully disengage with biomedical language. Additionally, I argue that policies that adopt socially-oriented discourse are not necessarily congruent with a social approach to mental health based on the social model of disability.

Finally, I argue that the inconsistencies in mental health care discourse trouble the debates surrounding the medical/social divide in trans studies and call into question the usefulness of the models of disability in categorizing approaches to TGNC mental health; the theoretical boundaries that delineate disability models do not necessarily translate well in practice. To challenge these theoretical boundaries, and to open new possibilities for nuanced engagements with biomedicine, I introduce Pamela Moss' concept of perching. Moss' perching model proposes that individuals can engage with biomedicine while remaining critical of its practices (Moss 2016, 223). I argue that this model can help make sense of not only discursive differences and the ineffectiveness of the medical/social theory dichotomy but can also help reveal the ineffectiveness of the male/female and body/mind binaries that are integral to maintaining these contradictory framings of TGNC mental health.

Organization

This thesis is organized into three distinct chapters. In chapter one, I situate my research within the broader context of trans studies, critical disability studies, and Mad studies. I also outline my theoretical framework, methodology, method, and data. In chapter two, I present a brief genealogy of "global mental health" as an idea, situating its emergence as a global health project within the history of madness in the global West. I consider the impact of international

framings of mental health, TGNC mental health in particular, within the global context as a precursor to my empirical evaluation of TGNC mental health policies and practices in Ontario. I end this chapter with an exploration of the biopolitical histories of sex/gender and madness, and how these two forms of power converge uniquely at the site of the TGNC subject. Chapter three contains my empirical analysis of mental health policies and practices in Ontario. The chapter begins with a brief overview of the federal structure of mental health care in Canada and Ontario and presents a brief review of mental health care institutions, systems, and policies in Ontario leading up to the recent increased interest in queer and TGNC mental health. Following this overview, I present the findings of my analysis, situating policies and practices within three distinct discursive approaches: biomedical, social, and mixed-discourse policies. I reflect on the consequences of these discursive differences using Foucault's concept of biopower, address the problems created by body/mind dualism, and use Margaret Price's concept of "bodymind" (2015) as an alternative to this division. Throughout this chapter, I integrate Pamela Moss' (2016) model of perching as both a theoretical and practical alternative to mainstream models of disability, which are unable to capture both the empirical nature of mental health policy discourse in Ontario and the unique lived experiences of TGNC subjects who engage with these health care systems.

Chapter 1: Critical Disability and Mad Studies Approaches to TGNC Mental Health

In this chapter, I locate my thesis within the context of two different literatures; (1) transgender mental health and (2) critical disability approaches to trans studies. I also outline my theoretical framework and describe my methodological approach. In my literature review, special care was taken to prioritize the voices of trans and gender-nonconforming scholars. The selected literature has been published post-1973, the year that homosexuality was removed from the DSM. The removal of homosexuality from the DSM was a pivotal moment for TGNC activists, as it demonstrated to the TGNC community that the American Psychiatric Association was willing to depathologize homosexuality, but not gender variance. Literature from trans studies that uses critical disability studies or Mad studies as a theoretical framework were prioritized due to their applicability to my research. Efforts were made to limit the literature from and critical disability studies and Mad studies to the Canadian context, although some literature employs debates from American perspectives[6].

Literature Review

Much of the available literature on TGNC mental health has been dominated by biomedicine and the psy disciplines (Bechard et al. 2017; Bockting et al. 2013; Clements-Nolle et al. 2001; Clements-Nolle, Marx, and Katz 2006; T. L. Hughes and Eliason 2002; Jordan 2000). Most biomedical and psychiatric research focuses on the psychological effects of certain health problems, not necessarily mental health diagnoses, including HIV/AIDS (Bockting et al. 2013; Clements-Nolle et al. 2001), substance abuse (T. L. Hughes and Eliason 2002; Jordan

[6] As Canadian political discourse and culture is often influenced by the United States, the use of American perspectives remains relevant. Literature that discusses American policies, however, have been omitted. Literature from the American Psychiatric Association applies in the Canadian context, as Canadian mental health policies are governed largely by their Standards of Care.

2000), and suicide[7] (Clements-Nolle, Marx, and Katz 2006). However, it is the conflation of trans and gender-nonconforming identities with psychiatric pathology in the form of Gender Dysphoria that is of most interest to this study.

That "TGNC mental health" is largely synonymous with Gender Dysphoria within scientific literature is a significant finding that deserves to be unpacked. In this thesis, I question the conflation of identity with disorder and challenge the politics of diagnosis more broadly. Testimony from TGNC patients has revealed that physicians, including doctors, psychiatrists, and psychologists, often assume that psychological distress in TGNC patients is the result of their gender identity, or that the dysphoria they experience has been caused by some flaw in psychological functioning (Bauer et al. 2009, 352–53). This conflation obscures socially produced problems, such as the insufficiency of the gender binary to describe the range of gendered experiences, and the psychologically traumatic effects of transphobia that are generated from these societal understandings of gender. Transphobia is "under researched, under addressed, and under acknowledged" (Benson 2013) in the psy disciplines, which has led to a growing number of critical responses from trans scholars and activists, as discussed later in this review. I argue that the focus on Gender Dysphoria often overshadows the needs and concerns of TGNC people who live with other psychiatric diagnoses, such as anxiety, depression, or bipolar disorder.

Bauer et al. identify a significant lack of policies that "accommodate trans identities or trans bodies, including the lack of knowledge that such policies are even necessary" (Bauer et al. 2009, 354). These institutional failures or "erasures" (Bauer et al. 2009, 354–55) range from not

[7] While suicide is a mental health issue, it is not the only mental health issue that needs to be addressed. Furthermore, the primary focus on suicide as a TGNC mental health issue also reinforces a tragedy narrative that frames TGNC futures as bleak (Truitt 2011).

being able to access prescriptions at pharmacies, due to discrepancies between legal and "chosen" names on identification markers, to the realization by many TGNC people that most health practitioners are either unfamiliar with TGNC people or purposefully discount the possibility that they exist (Bauer et al. 2009, 354–55). While significant advancements have been made since 2009, it is evident that the focus on Gender Dysphoria has led to the invisibilization of other mental health-related issues that the TGNC community experiences, including mood disorders, anxiety disorders, and suicide, may or may not be related to their gender identity and/or minority stress. Most policies analyzed in this thesis relate to gender dysphoria and its associated "treatments", speaking to the dominance of medicalized understandings of trans identities in government discourse. I attribute this visibility to the coupling of trans and gender-nonconforming identities with psychiatric pathology, which I explore in greater detail in chapter two. I argue that because trans and gender-nonconforming people challenge rigid societal expectations of gender so greatly, science, as an epistemological authority, has stepped in and tried to make sense of gender deviance, by relegating it to a pathological category. As many trans activist and scholars have suggested, gender deviance can only make sense as a pathology to cisgender[8] people, as being trans or gender-nonconforming challenges the rigid sex/gender binary that feels invisible and natural to cisgender people, who have never had their identity questioned (see Enke 2012; Serano 2014). However, it is also important to note that having a diagnosis of Gender Dysphoria "can be validating for some people" (Olson-Kennedy qtd in. Stieg 2017).

Finally, while a significant portion of the literature on TGNC mental health addresses the barriers to accessing mental health services, there is little consideration as to how policies and

[8] Cisgender is a term used to refer to people who identify with the gender they were assigned at birth. The prefix "cis" is a Latin term that means "on the same side as".

practices produce and sustain these barriers. Furthermore, little attention is paid to the content of policy discourse surrounding TGNC mental health, with critical disability and Mad studies discourse existing outside of policy debates. This exclusion is not totally surprising, as both critical disability and Mad studies have grown out of grassroot movements that have historically opposed institutional governance (Davis 2016, n.p.; Meekosha and Dowse 2007, 2008). However, we live in a society that remains governed by institutions, and, as I explain in chapter three, community-based care is not always an option for TGNC people, particularly those who seek out transition-related services. Consequently, I use the next section of my literature review to map key debates within trans studies, critical disability studies, and Mad studies to demonstrate the importance of their inclusion within policy studies, and how these disciplines can inform the study of health policy.

Critical Disability and Mad Studies Approaches to Transgender Studies

Critical disability studies and Mad studies are interdisciplinary fields that often interact with feminist, queer, and critical race theories (Goodley 2013, 631). Critical disability studies places disability at the centre of political struggles, offering theoretical models that seek to understand the different ways that individuals are defined as disabled or not (Withers 2012, 6). Mad studies has developed as a unique branch of critical disability studies, focusing solely on the experiences of "mad" or psychiatrized people (Menzies, LeFrançois, and Reaume 2013), using many of the same theoretical models. The importance of the integration of critical disability and Mad studies with trans studies is well explained by A. Finn Enke, who argues that disability studies provides a greater understanding of the fluid nature of dis/ability as it is better at recognizing that "bodies, abilities, and core identities change" (Enke 2012, 74). Enke also argues

that “ableist judgements and social gendering happen simultaneously” (Enke 2012, 74), to recognize the connection between notions of dis/ability and transness. Enke borrows the concept of in/visibility from disability studies to talk about the problematic politics of recognition within the TGNC community, urging trans and disability scholars to increase the interaction between their fields of study. However, there are several issues with critical disability and Mad studies approaches to trans mental health, as many studies fail to successfully integrate the harmonious approach Enke imagines. Rather, the literature is largely divided between two, isolated framings and critical approaches to TGNC mental health; the biomedical and social models of disability.

The Biomedical Model

In this thesis, I argue that biomedical approaches to TGNC mental health exist at the intersection of two processes of psychiatrization: the pathologization of madness/mental health, and the pathologization of gender deviance in the form of Gender Dysphoria as a psychiatric diagnosis. Biomedical approaches to dysphoria are predominantly rejected within trans studies literature and by trans and gender-nonconforming activists who have been harmed by being labelled “crazy”. This label has often justified negative, paternalistic treatment approaches to TGNC people and their mental health, which many TGNC people report as counterproductive in the process of recovery from mental illness or in the process of sex and/or gender transition, with numerous scholars and activists (Ault and Brzuzy 2009; Pilling 2014; Lev 2006; Spade 2003) advocating for the removal of trans diagnoses from the DSM. Both Pilling (2014) and Spade (2003) have used critical disability and Mad studies to critique biomedical approaches to TGNC mental health care, arguing that these approaches are overly reductionist and that they

medicalize[9] normal variations in human biology and/or behaviour. Both authors identify the pathologization of Gender Dysphoria as adopting a medical (Spade 2003) or biomedical[10] (Pilling 2014) model of disability. The biomedical model and its treatment-centred approach operates at the level of the individual and asserts that diseases or mental disorders are the cause of flaws in human biology (Withers 2012, 31).

However, biomedical approaches to TGNC mental health do not necessarily have to be negative. For example, there are many TGNC people who accept, and even desire, Gender Dysphoria as a psychiatric diagnosis. Having a diagnosis of Gender Dysphoria not only legitimates public and insurance funding for counselling and transition-related health care but can also validate a person's gender identity or the physical and psychological distress that accompanies feelings of dysphoria (Dewey and Gesbeck 2015, 38). Similarly, while the anti-psychiatry movement, and some Mad studies scholars, reject the pathologization of madness as biochemical disorders, some self-described Mad people accept, and even seek out, psychiatric diagnoses. By framing mental illnesses as biochemical imbalances, rather than flaws in personality, some people may feel relieved and/or validated, and are often more likely to seek out treatment.

Medicalization is not always a top-down process; some efforts to pathologize are advocated for by members of the public. For example, a recent article published in *PLOS ONE* by public health expert Lisa Littman, describes a new and controversial diagnosis called "rapid onset gender dysphoria" or ROGD (Wadman 2018). In the article, Littman details complaints

[9] Peter Conrad defines medicalization as "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad 1992, 209).
[10] In this thesis I will use the term "biomedical model" to refer to what many authors simply call the "medical model", unless using a reference to a specific author's usage of "medical". I prefer to use the term biomedical model as I recognize that there are social approaches to medicine that should not be associated with biology-based approaches.

from parents of trans children who claim that their children have "suddenly" declared that they no longer identify with the gender they were assigned at birth, arguing that this sudden declaration is not attributable to "real" gender dysphoria, but are rather the result of a social contagion that has children choosing to identify as transgender because they have transgender friends (Wadman 2018). The article has received significant criticism from Brown University, where Littman is employed, as well as trans activists and many parents of trans children. The main critique of Littman's article is its apparent lack of scientific rigor; Littman only spoke to parents, not the children themselves. Furthermore, the parents interviewed appeared to be recruited through websites frequented by transphobic parents, pointing towards a problematic selection bias (Wadman 2018).

While the name for ROGD has only just been coined in academic literature by Littman, the idea that being trans may be socially contagious is not a new one. In 2017, the term "trendsgenderism" appeared in an article on the issue of detransitioning, used by a parent of a trans child who disapproved for their child's gender identity, arguing that being transgender is part of a social "trend" among youth (Herzog 2017). Littman's definition of ROGD situates the phenomenon of "trendsgenderism" within biomedical discourse, medicalizing what has formerly been referred to as a purely social phenomenon. While the medical model is being used against transgender children in this case, the biomedical explanations of gender dysphoria could be used to delegitimate the concept of ROGD, by reinforcing the idea, however controversial, that Gender Dysphoria is a non-communicable mental disorder not attributable to social factors.

While medicalization is most often associated with harm, associated with increased stigma and psychiatric control of TGNC people and the transphobic mobilization of medical discourse to denounce trans children's gender identities, some TGNC people do endorse and

even internalize biomedical explanations for gender dysphoria, just as Mad people of all genders may feel legitimated by having a diagnostic category of symptoms applied to experiences of other forms of emotional distress. For example, TGNC activists in North America have argued in favour of maintaining GD as a registered mental illness within the DSM, if only because without this medicalized definition, many trans and gender-nonconforming people would not be able to have access to desired medical services such as sex reassignment surgery or hormone therapy (Drescher 2010, 427). For others, the biomedical approaches to TGNC mental health, Gender Dysphoria in particular, has served to validate individuals' identities as trans or gender-nonconforming people.

Littman's study is part of a broader debate about gendered brains within the neuroscientific community. A controversial set of news stories that circulated in May 2018 highlighted the findings of a scientific study, headed by Julie Bakker, which asserts that MRIs can help determine whether or not someone has a "transgender brain" (Knott 2018; Young 2018). Bakker argues that "brain activity and structure in transgender adolescents more closely resembles the typical activation patterns of their desired gender" (European Society of Endocrinology 2018) and that there are sex differences in the structure of "male" and "female" brains (European Society of Endocrinology 2018). While some have argued that the possibility of MRI tests as a diagnostic tool would help some people questioning their gender identity determine whether they are "really" transgender (Knott 2018) or that MRI testing would avoid sending people to psychiatrists in the hope that "their distress will disappear spontaneously" (European Society of Endocrinology 2018), others have understandably criticized Bakker's study, arguing that gender identity should be a personal choice, not a medical definition (Knott 2018).

Evidently, there is more than a singular biomedical model of TGNC mental health. Rather, there are several different approaches, both positive and negative, that adopt biomedical framings to fulfill personal motivations. These nuanced approaches to TGNC mental health within a biomedical model demonstrates a need for a more nuanced approach to the dominant literature on the biomedical model (see Ault and Brzuzy 2009; Pilling 2014; Lev 2006; Spade 2003). These differing approaches to a biomedical model of TGNC mental health have implications for my analysis and the associated conclusions in chapter three. It is important that evidence of biomedical discourse within mental health policies and practices in Ontario are not automatically conflated with harmful or transphobic attitudes toward TGNC people, despite the wealth of existing evidence that many medicalized approaches are indeed harmful.

The Social Model

In response to the biomedical model, many scholars have adopted the social model of mental illness to challenge psychiatric approaches to TGNC mental health, Gender Dysphoria in particular. For example, Pilling critiques biomedical approaches to mental health and TGNC mental health care for failing to consider how feelings of dysphoria might be the consequence of rigid societal definitions of the relationship between sex and gender, or that other forms of mental distress experienced by TGNC people is caused by living in a transphobic society (Pilling 2014, 14). In asserting this, Pilling adopts the social model of disability as an alternative mode of conceptualizing mental illness in TGNC people. Whereas the biomedical model understands madness as primarily caused by biogenetic factors (Pilling 2014, 266), the social model considers "social contexts related to people's experiences of madness, respecting and legitimizing people's accounts of their own experiences" (Pilling 2014, 79). The social model

sees mental illnesses as socially constructed. Disability is not inherent to the body; it is society that disables people (Withers 2012, 86). In a series of qualitative interviews with self-identified queer and trans people, Pilling's research reveals that many of the participants in the study identified the source of their psychological distress as being caused by homophobia, transphobia, or other forms of identity-based discrimination, all socially constructed forms of suffering (Pilling 2014, 5).

Alternative Models of Mental Illness in Critical Disability and Mad Studies

However, some queer and trans disability scholars have advocated against, or beyond, the social model, finding it quite limiting in its approach to the diverse realities of disabled/Mad people, as the model forwards a narrow definition of what constitutes disability (Terzi 2004; Withers 2012). Arguing that disability is caused solely by social forces leads to a failure to account for impairment as a concept distinct from disability, and the complex relationship between impairment, disability and society (Terzi 2004, 141). For example, Allison Kafer argues that "the social model can marginalize those disabled people who are interested in medical interventions or cures" (2013, 7). The social model reduces disability to a consequence of oppressive structures, ignoring pain and impairment. For Kafer, this limitation diminishes "our ability to conceive of a non-disabling world, of which pain and impairment are a real part" (Kafer 2013, 8). Similarly, Alexandre Baril critiques the social model for equating trans distress with purely external, society-based oppressions. Accounting his experiences as a trans man, Baril remarks that the distress felt by many trans and gender-nonconforming people is not externally caused; rather, the source of the distress comes from within (Baril 2015, 62). Contrarily, both Beresford and Pilling have argued that many people who experience mental distress, such as

dysphoria, do not perceive this distress as an impairment, and that impairment reinforces biological essentialism (Beresford 2004; Pilling 2014).

From an economic perspective, the social model of mental illness and the demedicalization of Gender Dysphoria have been criticized for failing to address class issues related to hormone treatments and other transition-related services, including surgery and counselling (Withers 2013, 35). In Ontario, individuals seeking hormones and sex reassignment surgery (SRS) are not eligible for funding without a trans "diagnosis" (Levine and Solomon 2009, 44). In these circumstances, the social model of mental illness cannot attend to the medical and economic needs of individuals who feel that transitioning is integral to their overall physical, psychological, and social wellbeing. The adoption of a purely social approach to TGNC mental health would be to follow an idealistic policy model instead of trying to accommodate for the realities of current lived experiences of TGNC people in Ontario. While society does disable people, society is not the sole source of disablement for all. By considering impairment, we can adopt more inclusive understandings of the individual needs and wants of TGNC people and avoid reducing the diverse individuals within the TGNC community to a homogenous group with universal needs.

In this thesis, I adopt Carol Thomas' definition of impairment. Thomas defines impairment as "the direct and unavoidable impacts that 'impairments' (physical, sensory, intellectual, emotional) have on individuals' embodied functioning in the social world" (Thomas 2013, 14). It is important to distinguish this definition from the use of the term "impairment" by the American Psychiatric Association as a necessary component of a psychiatric disorder. Many have pointed to the problematic ambiguity of the APA's definition of impairment, suggesting that it allows for the broad pathologization of TGNC subjects who experience varying degrees of

dysphoria and/or distress (Withers 2013, 22), but who may not necessarily feel that they personally experience dysphoria. In critiquing the APA's use of the term, however, we need to be careful not to discount the experiences of TGNC people who assert that feelings of dysphoria are individually internally distressing, and for whom a model that considers the impact of impairment may be more beneficial. Liz Crow critiques the social model and the "suppression" of natural or embodied distress. Crow argues,

> The suppression of natural concerns does not mean they cease to exist or suddenly become more bearable. What it does is undermine individuals' power to 'cope' and, ultimately, the whole Disabled people's movement. As individuals, most of us simply cannot pretend with any conviction that our impairments are irrelevant because they influence every aspect of our lives. We must find a way to integrate them into our whole experience and identity for the sake of our own physical and emotional well-being, and, subsequently, for our capacity to work against Disability. (Crow 1992, 4)

Searching for a compromise, many trans activists have advocated for the recategorization of Gender Dysphoria from a psychiatric to a physical disorder. The reclassification of Gender Dysphoria as a physical disorder would enable TGNC patients who wish to transition retain the necessary medical legitimacy for insurance claims, while distancing Gender Dysphoria and transness from a psychiatric control, discourse, and the associated stigma (Withers 2013, 29). This compromise has been met with hostility by numerous critical disability and trans scholars who cite ableism as a key issue. While the desire to be free from stigma is both an understandable and legitimate claim, some activists, such as Kate Bornstein, argue that the depathologizaiton of transness may leave some members of the TGNC community behind (Bornstein in Withers 2013, 48), particularly for those who may not have the economic means to

transition without financial support, or for TGNC people who are pathologized for experiencing other forms of psychological distress beyond dysphoria (Withers 2013, 48).

Evidently, transgender and gender-nonconforming health is a complicated and multifaceted public policy issue that calls for significant improvement. The usage of the social model perpetuates a binary within the literature, which suggests that social approaches are the oppositional alternative to medical approaches. I argue that this binary positioning of biomedical versus social approaches does not fully encapsulate the reality of experiences that TGNC people have in relation to their mental health and experiences with mental health practitioners, nor do these binary accounts consider the nuances of biomedical and/or social mobilizations of TGNC mental health. The failure of the biomedical and social models to fully encapsulate the range of TGNC attitudes toward biomedicine and their experiences reveals a theoretical gap that must be bridged through the introduction of other epistemological perspectives relating to mental health. TGNC disability discourse is often sanist, ableist, and classist, calling for a more intersectional analysis across these three areas. Therefore, I explore, critique, and contribute to literature that adopts critical disability and/or Mad studies approaches to TGNC mental health to bridge the gap between the medical and the social models of TGNC mental health. Seeking alternatives, I explore three approaches that challenge both the biomedical and social models of disability in the following section; the biopsychosocial model (Engel 1977), the radical model of disability (Withers 2012), and perching (Moss 2016).

The Biopsychosocial Model

George Engel's biopsychosocial (BPS) model is unique in comparison to other models that challenge the biomedical approach, as it does not completely reject the contributions of

biomedicine. Rather, the BPS model views the biomedical model as insufficient in explaining the cause of mental and emotional distress. The model argues that for medical professionals to adequately understand their patients' experiences with illness or disease, they must take into consideration the biological, physiological, and social dimensions of illness (Borrell-Carrio et al. 2004, 576). In comparing diabetes and schizophrenia, Engel demonstrates that biochemical abnormalities are necessary but insufficient for determining the presence of an illness, as how an individual experiences biochemical abnormality in the form of a symptom relies on psychological, social, and cultural factors (Engel 1977, 132). Psychological reactions to life may interact with somatic factors that affect the onset and the severity of the disease (Engel 1977, 132). This argument is compelling, particularly as it applies to experiences of dysphoria in TGNC individuals. Some TGNC activists have argued for the removal of Gender Dysphoria from the DSM on the basis that not all trans or gender-nonconforming individuals experience the psychological distress necessarily associated with the psychiatrized definition of dysphoria, or that their distress is related to and within the body, as opposed to the mind.

While a model that accounts for the varied embodiments of psychological distress in relation to the body can straddle the line between the biomedical and social binary that has been established in TGNC mental health literature, the biopsychosocial model is not without its limitations. Engel adopts a systems theory approach in the development of his model (Engel 1977, 134). Systems theory has its origins in biology and is fundamentally hierarchical. Engel's approach to understanding and diagnosing "problems of living" (Engel 1977, 133) suggests a linear progression of symptomatic experiences, starting at the base level of the biological cell, moving upward to the individual's psyche and finally, beyond the body into the society within which the individual is situated. This prioritization of the biological establishes a uniform

application of the model that is not conducive to an analysis of TGNC engagement with biomedicine, due to the diversity of experiences surrounding dysphoria and gender identity in the TGNC community.

Furthermore, the prioritization of the biomedical within this model fails to challenge the role of medical gatekeeping. The model also centres the medical expert as the keeper of knowledge, which is problematic for TGNC people. As Enke argues, "trans scholars and activists have noted [that] normativity maintains itself in part by ensuring that only people who do not trans some boundary of sex-gender can be the experts on the trans subject's sex/gender" (Enke 2012, 75). Within the BPS model, the physician is the one who is permitted to determine the extent to which biological, physiological, psychological, social, and cultural contexts have on determining illness. Therefore, this approach still upholds an imbalance of power between physician and patient, which has the potential to be oppressive through the physician's subjective use of diagnostic power (Pilling 2014, 4).

The Radical Model of Disability

The radical model of disability is a relatively new model that has been informed by "feminist, anti-racist, anti-capitalist and postmodern theory" (Withers 2012, 98). The radical model of disability seeks to address both oppressive practices (disablism) and disabled minds and bodies (impairments), rather than focusing solely on oppression, as does the social model, or individual flaws, as does the biomedical model (Withers 2012, 98). The model rests on four key assertions: (1) that intersectional approaches are necessary, (2) that normality is arbitrary, (3) that disability is a political, rather than a biological determination, and (4) that accessibility must be approached holistically as opposed to universally (Withers 2012, 98-9). Situating themselves as a

disabled trans person, Withers encourages the TGNC community to adopt the radical model of disability when approaching psychiatry (Withers 2012, 102). The assertion that disability is a political, rather than a biological determination comes into play in the case of the TGNC community's relationship to psychiatry and challenges the assertions of those who strictly adhere to the social model by reclaiming the disability label as a means of challenging the medical system and its existing power structures (Withers 2012, 102). While Mad studies and Mad activism seek to distance psychiatrized people from the "umbrella of disability" (Withers 2012, 102), Withers notes that the TGNC community has not been able to reach a consensus on the matter, citing the poor socioeconomic realities of many TGNC people, which necessitates the pathologization of trans identities in exchange for insurance coverage (Withers 2012, 102).

Furthermore, this need for Mad studies to distance itself from the disability label reinforces disablism, defined as "the oppressive practices of contemporary society that threaten to exclude, eradicate, and neutralize" bodies, minds, and practices that do not align with capitalist ideals (Goodley 2014, xi). The claims of psychiatrized people that they are not disabled because there is nothing wrong with them reinforces the idea that those who are disabled are flawed or inferior to those who are not (Withers 2012, 103). In contrast to the social model, Withers' radical model advocates for the acceptance of the disability label. Like Mad activists, Withers views labelling as an inherently political act (Withers 2012, 105). The crucial difference between Mad activism and the radical model is that while Mad activism seeks to gain power through avoiding the disability label, the radical model believes that power is gained through the acceptance or reclamation of "disabled" as a label. As Withers argues, the adoption of the radical model "would problematize the entire disability labelling process" (Withers 2012, 105), displacing the discursive/diagnostic power of psychiatric medicine and placing it in the hands of

marginalized individuals who are forced to engage with the institutions that have historically oppressed them. While this model is critical, in that it challenges the hierarchies that enable the pathologization of TGNC people, it remains idealistic within the current policy landscape in Ontario. Therefore, I turn to "perching" (Moss 2016), another critical approach to biomedicine that adopts many of the same values as the radical model, particularly the idea that individuals should have more decision-making power in their "treatment" plans, but which does not require a complete rejection, or demonization, or biomedicine. I view perching as an excellent strategy for the interim, allowing individuals to engage with biomedicine to receive the care they want and/or need in the absence of more radical approaches to health care, such as the informed consent approaches to mental health and/or transition-relates services for TGNC people.

Perching

Moss defines perching as "a practice of positioning oneself within biomedicine while maintaining a critical view of it" (Moss 2016, 223), disrupting hierarchical engagements, challenging the idea perpetuated within mainstream critical disability studies that the biomedical and social models are inherently oppositional, and rejecting the argument that to engage with one model or approach is to completely disengage or disavow the tenets of the other. Moss' application of the perching model uses the case of patients living with Myalgic Encephalomyelitis (ME). Both ME and Gender Dysphoria are characterized as contested illnesses, although they are contested in different ways. In the case of ME, biomedicine has contested the validity of the illness; for Gender Dysphoria, patients contest the validity of the pathology. For ME patients, seeking a medical diagnosis is a form of legitimacy, since their symptoms and concerns have been largely dismissed as psychosomatic by medical professionals

(Moss 2016, 224); individuals want to be diagnosed/pathologized to receive relief from their pain and distress. For TGNC patients, participating in perching would allow for a different form of legitimacy-seeking by permitting TGNC individuals to engage with biomedicine to receive the diagnosis of Gender Dysphoria to secure access to transition-related medical services and surgeries. Perching also allows for choice – individuals may choose to reject biomedical engagements as well, a decision would should be considered equally legitimate.

Perching allows us to accept that the relationship between the biomedical and the social is often troubled by realities present in health care policy that necessitate interactions with biomedicine to gain access to health services, benefits, and even life insurance (Moss 2016, 236). However, access to these services and benefits often depends on the attainment of a diagnosis (Moss 2016, 236), as a sign of a legitimate declaration of need or worthiness. As explored above in my analysis of critical disability and Mad studies approaches to trans mental health, Gender Dysphoria, as a psychiatric diagnosis, gives power to biomedical and psychiatric institutions to identify "real" trans people from those who are simply confused or who have an underlying psychiatric condition that may be altering their sense of reality. As TGNC activists have noted, while Gender Dysphoria is seen by many to be oppressive, it is often a prerequisite for attaining care, as is the case in Ontario (Ontario Ministry of Health and Long-Term Care 2016). The reality of this medical gatekeeping model means that many TGNC people, regardless or personal feelings toward Gender Dysphoria as a diagnosis, or biomedicine as an institution, are often forced to engage with biomedicine to meet their physical, mental, and emotional needs.

Unlike the biopsychosocial and radical models, perching is a non-hierarchical approach. Most importantly, however, a perching model works in the present, as it provides mental health patients/consumers/survivors/ex-patients (p/c/s/x) with the tools to navigate oppressive systems

that cannot transform overnight. While certainly not a definitive solution to biomedical gatekeeping and the pathologization of TGNC people, perching does give TGNC p/c/s/x the option of engaging with biomedicine when it is necessary or desired for legitimation; perching rejects the idea that engagement with biomedicine is an inherently oppressive and disempowering interaction. In the experiences of patients with ME, perching on the edge of biomedicine presented opportunities where patients could "challenge one's own oppression, marginalization, and powerlessness through micro-instances of the exercise of power" (Moss 2016, 229) and that "subjects produced through the discursive and material elements of biomedicine do not have to reproduce the existing set of relations" (2016, 227). In this way, perching affords more agency to individuals who engage with biomedicine, unlike proponents of the social model would suggest.

In summary, my review of the literature has revealed the following key points. Firstly, dominant perspectives on TGNC mental health are largely approached from a psychiatric, biomedical perspective, focused on diagnosing and understanding gender dysphoria as a psychiatric disorder. Critical responses and epistemological alternatives to these approaches have proliferated within trans studies, mobilizing theories and concepts from critical disability and Mad studies. However, there are significant problems with the integration of disability studies in TGNC mental health literature. Major critiques of psychiatry within trans studies adopt the social model of disability and are overwhelmingly sanist and ableist (Ault and Brzuzy 2009; Bauer et al. 2009; Lev 2006; Levine and Solomon 2008), as they seek to distance Gender Dysphoria from the labels and stigma of disability and madness, reinforcing both as negative constructions. I contrast these perspectives with a growing number of critiques from trans studies, critical disability studies, and Mad studies that seek to address these critical failures, including perching,

as a way of both amplifying these critical responses and to demonstrate the need to identify and analyse discourses within Ontario mental health policies.

Second, transgender studies literature on mental health has been dominated by a binary analysis of the medical versus the social model of mental illness. I argue that this binary representation essentializes the experiences of TGNC individuals, polarizing debates and ostracizing individuals who choose to – or must engage with – biomedicine. The unique experiences of TGNC individuals exist outside of this medical/social binary. Based on these three major findings of my literature review, I have formulated the following three research questions, as previously outlined in my introduction: First, how is mental health framed in institutional policies and practices in Ontario that govern TGNC mental health and/or Gender Dysphoria? Second, what type of subjects do these policies and practices create? Third, how might we challenge the medical/social model dichotomy regarding gender dysphoria and TGNC adults?

Theoretical Framework

To answer these questions, my work is informed by three theoretical approaches. Firstly, I use Carol Bacchi's "What's the Problem Represented to be?" (WPR) approach (Bacchi 2016) to situate my epistemological approach to policy problems. Complementing this framework, I adopt Foucault's conception of biopower to answer questions related to the construction of mental health as an idea and the coupling of TGNC identities with mental health. Additionally, I use biopower to explain the consequences of the various policy discourses that I identify in chapter 4. Finally, I draw from critical disability studies and Mad studies' theoretical approaches

or “models” of disability and mental illness, as outlined in my literature review, as tools for evaluating policy discourse.

What is the Problem Represented to Be?

Bacchi’s WPR approach is a tool designed for discursive approaches to policy analysis, rooted in policy framing theory. The model assumes, through a unique epistemological approach, that problems do not exist “out there”, waiting to be discovered (Bacchi and Eveline 2010, 111). Rather, problems are “discursively produced” (Bacchi and Eveline 2010, 111), coming into existence through the process of policymaking. This approach draws from Foucauldian poststructuralism, which focuses on “the plurality of practices that produce hierarchical and inegalitarian technologies of rule” (Bacchi 2016, 8). I adopt this epistemological approach in my research as it is crucial to understand how policy discourses contribute to a process of creating, shaping, and knowing the world, including who can act in or upon it (Van Hulst and Yanow 2016, 100). Proponents of policy framing or discursive approaches, including Bacchi, often forward the argument that policies create people, a concept that cannot be taken for granted in the context of TGNC lives, considering that TGNC people have been historically excluded from the category of “people” from a biopolitical perspective, as they have not been considered crucial or useful to the cultivation of the body politic (Stryker 2014, 40). Insofar as TGNC people are considered “people” today depends on the decisions of so-called experts, including psychiatrists and doctors, who use biomedical definitions to grant personhood and verifiable “transness”, justifying the importance of studying policy problematizations in the context of my own research. Therefore, WPR informs my methodological approach to understanding how policies

surrounding gender dysphoria are produced, and why it is necessary to focus on discourse before we can begin to understand the effects that a policy has on its target population.

Biopolitics and Biopower

In this thesis, I use Foucault's concept of biopower to explain two key phenomena: (1) how sex/gender became to be coupled with madness, uniquely affecting TGNC subjects, and (2) how policy discourses affect the (un)livability of TGNC lives through subjectification.

Foucault argued that central tenet of biopower is the focus on sex as a central site of discipline and regulation (Foucault 1978, 146), asserting that one of the crucial sites of power mobilization is through the control of the reproductive capacities of individuals, including health, birth, and mortality, necessitating disciplinary practices to ensure that individuals are acting in the best interest of the state (Foucault 1978, 146–47). While there is a stark absence of gender analysis in Foucault's discussion of sex, which Stryker attributes to the anglophone origins of the sex/gender distinction (Stryker 2014, 39), Stryker nonetheless argues that "gender as an analytical concept is commensurable with a Foucauldian perspective on biopolitics" as "gendering practices are inextricably enmeshed with sexuality" (Stryker 2014, 39). Gender is also subject to social categorization practices and the degree to which biological sex is perceived as fixed (Stryker 2014, 39). For example, in Foucault's introduction to the memoirs of Herculine Barbin, an intersex person living in 19th century France, Foucault explains how society's attitudes toward intersex[11] people developed over time, necessitating medical intervention only after ambiguous sex characteristics were rendered abnormal following the rise of biological medicine (Foucault 2013, viii). The pathologization of TGNC people has followed a similar

[11] Foucault uses the outdated term "hermaphrodite" (Foucault 2013, vii)

trajectory, rendered pathological via the biopolitical histories of both sex and madness.[12] While both state and society are increasingly learning the division between sex and gender, we can categorize TGNC people as belonging to a distinct, yet diverse, sex category upon which power is enacted. Gender Dysphoria diagnoses and gatekeeping models force a certain idea of who can be TGNC (people who accept these diagnoses) and how (by medically transitioning). These prevailing categories, male and female, normalize cisgender bodies, facilitating the pathologization of trans, non-binary, and gender non-conforming bodies. Therefore, intervention is developmentally necessary – not just by the state, but also by doctors and psychiatrists (Owen 2014, 23).

I also use Foucault's biopower to explain the impact of policy discourses on the (un)livability of TGNC lives. I use this understanding of political power to explore my second research question, which asks what kind of subject(s) mental health policies and practices in Ontario create. Foucault argues that the body is a site of power and resistance in modern Western societies; it becomes a "political field inscribed and constituted by power relations" (Foucault in Deveaux 1994, 224). As the above discussion has shown, this new form of power has been associated with the rise of biomedical discourse, which has maintained its agenda-setting role in the contemporary age, exercised through research and the publication of diagnostic texts, including the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). In adopting Foucault's assertion that modern state power manifests in the control of bodies, it is easy to see how TGNC mental health policies, particularly those governing Gender Dysphoria and transition-related services, can be understood as sites of power and subject creation.

[12] See chapter two for an in-depth exploration of this argument.

Models of Disability and Mental Illness

As outlined in my literature review, models of disability and mental illness have influenced the study of TGNC mental health and have become polarized through sanist[13] assumptions and the negative nature of mental illness. In this paper, I seek to understand the models of disability and mental illness under a single approach[14] to help close the gap between body and mind, integral to the conceptualization of TGNC mental health. Using the biomedical and social models of disability as analytical benchmarks, I examine policies to see if the biomedical versus social binary that is upheld in trans studies literature is present in policies that affect TGNC adults in Ontario. As discussed in my literature review, I have argued that the binary relationship between the biomedical and social models is unhelpful when conceptualizing approaches to TGNC mental health, as it supports an ableist, sanist move away from disability, and fails to account for the economic realities of many TGNC people who seek to engage with biomedicine. Therefore, I amplify the use of alternative models, namely Moss' perching[15] model, to critique these approaches, and to allow for a broader range of analysis.

Methodological Approach and Methods

In this thesis, I use critical discourse analysis (CDA) to trace the use of disability model discourses present within TGNC mental health policies and practices in Ontario. There are three main components to CDA. First, CDA requires an object of analysis (Fairclough 2013, 21). In this thesis, the objects analyzed are public policies and practices in Ontario relating to mental

[13] Sanism refers to "the ways in which diagnoses and labels of mental illness result in stigma and discrimination and constitute a form of inequity" (Morrow 2013, 327).
[14] Although I seek to bring these two theoretical disciplines together, I recognize the unique contributions of each, specifically the efforts of Mad studies scholars to forge a discipline to address the unique needs to psychiatrized people, who have often been excluded from mainstream disability studies (Withers 2012, 102–3).
[15] Although not a model of disability, it is a useful theoretical model nonetheless.

health and the trans and gender-nonconforming communities. Object analysis is done via description, which I perform in chapter three. Secondly, critical discourse analysis requires an examination of the production of the text object and how it is received (Fairclough 2013, 21), analyzed via interpretation. This interpretation must address "institutional position, interests, values, intention, desires, etc. of producers" (Fairclough 2001, 10-11). I address this element of CDA in both chapter two and chapter three of this thesis. In chapter two, I focus on the production of mental health as an idea and global discourses of mental health, using critical perspectives from trans studies, critical disability studies and Mad studies to address the unique positions of global mental health policy actors and discourses that affect the production of mental health policy texts, most notably the World Health Organization (WHO) and the American Psychiatric Association (APA). This element of CDA also helps to establish the broader policy universe that van Dijk argues is critical to discourse analysis within policy studies to ensure a more integrated and thoughtful analysis of policy texts (van Dijk 1993, 250). In chapter three, I use textual analysis[16] to identify the presence of the different discursive approaches to TGNC mental health in Ontario mental health policies and practices. This part of my analysis is guided by a set of key terms[17] used by Bonnie Burstow to describe and challenge biomedical or "governmental" terms with "reclamation" terms often used by Mad people, anti-psychiatry activists, and Mad studies scholars (Burstow 2013, 83). The aim of these analyses is not to code policies based on the number of times a term is used within the text. Rather, this analysis seeks to search for key terms that identify the presence or absence of medical and/or social or "reclamation" language (Burstow 2013, 83) to gain a better understanding of how policy

[16] Critical discourse analysis has its origins in textual analysis (Tenorio 2011, 183).
[17] The full list of terms is available in Appendix A.

discourses constitute the creation of certain subjects through permitting certain types of action, which can be done without coding.

The third major element of critical discourse analysis, according to Fairclough, is the examination of the socio-historical conditions that govern the discursive processes and interpretations of objects of analysis, which are analyzed through explanation (Fairclough 2013, 22). I address this element of critical discourse analysis in both chapters two and three, through detailing the history of TGNC mental health at the global level (chapter two) and the shifting mental health policy landscape in Ontario following deinstitutionalization in the 1970s (chapter three).

Critical discourse analysis is well suited to the nature of my study as this methodological approach is primarily interested in the relationship between language and power (Weiss and Wodak 2003, 12), which culminate in the problem definition stage of the policy cycle. Furthermore, the interdisciplinary and intersubjective nature of CDA allows for the interaction of different theories and concepts, facilitating the production of truly interdisciplinary work that draws from a wide range of scholarly disciplines, as I have outlined in my literature review.

Data

The data I will be using to answer this question are policies that address one or more of the following concepts: "mental health," "trans* health," "trans* mental health," "trans* mental illness," and/or "gender dysphoria." This broad choice in categories of policies allows for overlap and considers the ways in which non-mental health policies might constitute regulations surrounding mental health care. While my research is staged within the context of Ontario, federal policies and strategies will also be analyzed, insofar as they apply at the provincial level.

I have taken care to source non-governmental policies as well, including policies from Rainbow Health Ontario and the Centre for Addiction and Mental Health, to provide a clearer picture of the extensive universe of discourse related to TGNC adults and mental health in Ontario.

To address my second research question, which questions the type of subject(s) that mental health policies and practice create, I employ critical discourse analysis again to trace the use of language within policies. I am particularly interested in whether policies and practices view trans and gender-nonconforming subjects as sick or not and will be determining the orientation of the language using Burstow's terminology chart. Terms that would signal the creation of a medicalized, pathologized, or sick subject would include "mentally ill", "mental patient", "psychiatric patient", and "mental illness" (Burstow 2013, 83). The use of refusal terms such as "consumer", "psychiatric survivor", or "wellbeing" (Burstow 2013, 83) would signal a type of discourse that is more closely aligned with the social or radical model of disability.

In this chapter, I have presented a review of the existing literature on TGNC mental health, summarizing critical disability and Mad studies approaches on the issue. I have critiqued the binary positioning of biomedical and social approaches to TGNC mental health and introduced an alternative model, perching, to challenge the assumption that one model must prevail over the other. I have also outlined by theoretical framework and methodology, situating myself within a poststructuralist, Foucauldian approach to policy studies.

I now turn to an overview of the history of madness and mental health to understand the context within which questions of mental health and mental health policy have been created. While the focus of this thesis is on policies and practices in Ontario, Canada, it is important to consider the broader context of global mental health, as this enables the adoption of a more integrated approach to discourse analysis and takes into consideration the various "modes" (van

Dijk 1993, 250) of discourse power-relations and how these modes are reproduced (or not) in the governance process (van Dijk 1993, 250).

Chapter 2: Global Mental Health, Mental Health Policy, and the TGNC Subject

In this chapter, I use Foucault's account of the history of madness to contextualize the advent of global mental health, arguing that the medicalization of madness in the nineteenth century enabled the universalization of biomedical approaches to mental health. I also use the work of Okpaku and Biswas (2014) to trace the development of global mental health through three different "epochs" and outline some of the major critiques of global mental health.

Following this brief overview, I present arguments surrounding psychiatry's "boss texts" (Burstow 2015, 18), the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). Burstow defines boss texts as "texts higher up in the hierarchy that influence both the creation and the deployment of other texts" (Burstow 2015, 18). I offer an overview of these documents as they represent the dominant discursive perspectives on mental health in an authoritative, tangible form. As will be discussed, both documents have been the target of major criticism, particularly from the anti-psychiatry and Mad pride movements. I demonstrate how both the ICD and the DSM have shaped, and re-shaped, global understandings of psychiatry and psychology and how both queer and/or TGNC people have been sequestered into their own unique categories of madness, treatment, and cure, alongside the ideological discourses of global mental health.

What is Global Mental Health?

What is known as global mental health can be more accurately identified as "the globalization of Western mental health" (Summerfield 2012, 519) and is a relatively new field (Clark 2014, 1). Interestingly, "global mental health" originated in 1802, around the same time as the medicalization of madness (Foucault 2011, 106), which occurred at the turn of the nineteenth century. According to Foucault, the rise of scientific medicine following the Enlightenment

meant that madness was no longer seen as a form of religious-based insanity (Foucault 2011, 109). Prior to the nineteenth century, "madness was regarded as someone 'possessed'" (Foucault 2011, 106); religion took on the role of cure, exorcising people of possession and even colluding with science and medicine as a "preliminary" treatment before the asylum (Foucault 1973, 243–44). Scientists reframed this idea of supernatural possession to a form of illness, asserting that "divine madness" was simply "unrecognized" mental illness (Foucault 2011, 106). As Foucault writes, "it was only with the arrival of the calm, objective, scientific gaze of modern medicine that what has previously been regarded as supernatural perversion was seen as a deterioration of nature" (Foucault 2011, 107). This saviour-like attitude is a theme that has carried into modern day biomedical discourses, justifying the mobilization of global mental health programs.

Okpaku and Bismas argue that the development of global mental health can be divided into three distinct "epochs" (Okpaku and Biswas 2014, 1). The first epoch (1802-1887) was primary led by two individuals, Dorothy Dix and Clifford Beers, both non-psychiatrists with lived experiences of mental illness. Both Dix and Beers were invested in improving the conditions of state asylums. Dix travelled as far as England to help improve the welfare of people living in "treatment centers" under abusive conditions. Beers developed the American Mental Health Movement, which became the foundation for the International Committee for Mental Hygiene (ICMH). The IMCH would eventually develop into the World Federation for Mental Health, developed by George Chisholm following World War II (Okpaku and Biswas 2014, 3), which Okpaku and Bismas identify as the "second epoch" of global mental health (Okpaku and Biswas 2014, 1). The second epoch also saw the creation of the World Health Organization at the United Nations, which remains one of the most prominent organizations in the global mental health arena.

The World Health Organization (WHO) is the "directing and coordinating authority on international health within the United Nations" (World Health Organization 2018b), devoted to health promotion, disease prevention and treatment, crisis management, research, and surveillance (World Health Organization 2018b). Regarding mental health, the WHO is concerned with "the promotion of mental well-being, the prevention of mental disorders, the protection of human rights and the care of people affected by mental disorders" (World Health Organization 2018a). At the centre of the WHO is the desire to structure a global mental health scheme that will better address the global "burden" of mental disorders (Cooper 2016, 355; World Health Organization 2018).

Finally, Okpaku and Bismas locate the third epoch of global mental health within the "contemporary" era, influenced by the rise of human rights, advocacy, ethics, and the mass media (Okpaku and Biswas 2014, 6-7). The third epoch has been characterized by the increased "scaling up" of global mental health programs, enabled by increased availability of financial resources through the United Nations and the International Monetary Fund.

Critiques of Global Mental Health

Jocalyn Clark critiques the global health movement through the lens of medicalization (Clark 2014, 2). Clark argues that early framings of global mental health "emphasised biological disease, linked psychiatry with neurology, and reinforced categories of mental health disorders" (Clark 2014, 1). Just as Foucault argued that Western medicine claimed to have discovered madness for what it truly was, Summerfield argues that the reported 30 per cent increase in mental health disorders each year is not a symptom of growing disease, but rather, a "discovery" of Western biomedicine. Summerfield writes,

> Presumably, the people from whom these disorders are hidden include the millions supposed to be carrying them, but [only] the Western-trained expert knows where to find them and what to do. (Summerfield 2012, 4)

While global mental health programs are often framed as altruistic, critiques of global mental health programs, including those by Clark (2014), Howell (2011), and Summerfield (2012), have framed the idea of global mental health as a form of neocolonialism that seeks to securitize "unstable" populations and which ignores the cultural relativity of what constitutes "mental health". As argued by White, the concept of "global mental health" is less of an objective public health problem and more of a discursive product of the exportation of Western medical concepts to lower and middle-income countries (White 2013, 2). Both globalization and universalization are the two central goals of the global mental health project; to universalize diagnosis and care for the management of populations (Clark 2014, 1), linking the standardization of mental health diagnoses to Foucault's conception of biopower.

Within global mental health literature, the role of psychiatric pathologization has been linked to global population management in the form of international security. As Alison Howell writes, "the psy disciplines have are often intrinsically involved in security problematizations and ordering practices" (Howell 2011, 48). Psychiatric disorders are treated not only to help relieve individuals of their suffering, but to establish and maintain security and order in entire populations (Howell 2011, 48). Psychiatric discipline is also mobilized in this way to manage various types of international security issues, from conducting interventions in post-conflict zones to educate "local populations in proper mental conduct" to "ensure security and order" (Howell 2011, 49), to teaching Canadian soldiers to "self-govern, and to manage the trauma of witnessing warfare" (Howell 2011, 49), so that they may not impose a burden on the state, and that they may be ready to be redeployed as soon as possible (Howell 2011, 113–14).

Psychiatric interventions are not only used for the purposes of *international* security, however. They can also be used to securitize social mores and maintain order through the maintenance of social values, such as gender; the rise of science in the nineteenth century also enabled the medicalization of trans and gender-nonconforming people. Foucault accounts this process in his introduction to the memoirs of Herculine Barbin. Just as modern Western societies sought to find the scientific, objective truth in madness, Foucault argues that Western societies have also been preoccupied with the idea of defining the "true sex" (Foucault 2013, vii). Accounting the history of "the hermaphrodite" (Foucault 2013, viii), Foucault demonstrates how hermaphroditism, like madness, was once left unregulated by scientific intervention. It was not until the rise of "biological theories of sexuality, juridical conceptions of the individual" (Foucault 2013, viii) and "forms of administrative control" (Foucault 2013, viii) that the idea of two sexes within a single body came to be understood as biological accident requiring medical intervention to "strip the body of its anatomical deceptions" (Foucault 2013, viii). While hermaphroditism, now referred to as intersexism, is different from being trans or gender-nonconforming, the idea that there is a true sex, and that medicine must necessarily intervene to correct any mental or physical deviation from what is deemed to be true, is an idea at the forefront of TGNC mental health care approaches.

This quest for a "true sex", within a globalized binary gender schema, is reflected in modern critiques of Gender Dysphoria. For example, Blue argues that for many TGNC people, their experiences of mental health problems and/or Gender Dysphoria does not fit the diagnostic "script" of dysphoria as published by the World Health Organization and the American Psychiatric Association (Blue 2018). For Blue, the DSM criteria for Gender Dysphoria did not align with their own personal experiences of being a trans femme person living in Ontario, which

led to the manifestation of depression, anxiety, and depersonalization. What Blue describes in their account of their lived experience echoes the arguments of anti-psychiatry activist Thomas Szasz, whose perhaps most famous argument was the idea that mental illness is a "myth" (Szasz 1974). Interestingly, Blue does not reject the labels of depression or anxiety in the same way as they find trouble with the diagnosis of Gender Dysphoria. Perhaps for Blue, the problem is not necessarily that mental illness is a "myth", but that the requirements for fitting under the label of "trans" feels unattainable or elusive, as one might describe a mythical creature. For Blue, the definition of Gender Dysphoria, influenced by the globalization and universalization of mental health, has created such a rigid understanding of what it means to be TGNC, which some, like Foucault and Szasz, would attribute to the turn of the nineteenth century and the medicalization of madness.

As Szasz writes, mental illness and the development of psychiatry occurred through the "transformation of a religious ideology to a scientific one" (Szasz 1997, xxiv). Science rationalized the fearful view of the witch or heretic to an individual with an identifiable and treatable sickness (Szasz 1997, xxiv). Szasz argues that the state seeks to provide care for mentally ill people because they are perceived as unable to make rational decisions in their best interest (Szasz 1997, 43). In the context of global mental health care, we can see how the focus on increasing services in low and middle-income countries can see seen as a type of governmental paternalism, laced with racist and neocolonial attitudes that view LMICs (predominantly non-western countries) as incapable of taking care of the mentally ill among their populations, what Derek Summerfield calls "medical imperialism" (Summerfield 2013, n.p.).

Additionally, global mental health discourse has been critiqued for catastrophizing mental illness, using "disease mongering" (Summerfield 2012, 520) phrases such as "public

health challenge" (Patel et al. 2007, 1302) and "global burden" (Ustün 1999, 1315), leading to an increased interest in global mental health governance that has justified the "scaling up" of global mental health services and programs (Okpaku and Biswas 2014, 5; White 2013, 182). One of these programs, the Movement for Global Mental Health, is a network organization working to improve services for people with mental illnesses, particularly those living in low and middle-income countries (Movement for Global Mental Health n.d.). The Movement's webpage states that their advocacy is based on "universalised western understandings of health, healing and personhood" (Movement for Global Mental Health n.d.), alluding to the Western imperialist nature of mental health programs.

Furthermore, the globalization of mental illness has been attributed to "the seductive allure of biological psychiatry" (White 2013, 182). Jocalyn Clark writes,

> Viewed through the lens of medicalization, global mental health is a fascinating phenomenon. As I have argued elsewhere there exists a paradox, which is growing as mental health is globalising: on one hand, badly needed attention to mental health issues and people's suffering is welcomed and essential, but on the other hand the predominance of medical framings of global mental health has created conditions for disease mongering and medicalization. (Clark 2014, 2)

Clark's recognition of the need for attention to mental health issues and suffering adds a welcome dose of nuance to mainstream critiques of biomedicalization and speaks to the problem with purely social approaches to TGNC mental health, which often fail to account for individual experiences of impairment and distress. In the following section, the tensions between the biomedical and social models of mental illness regarding TGNC mental health at the global level further complicate these debates while also providing context for textual analysis in chapter three.

TGNC Mental Health at the Global Level

Having explored the history of global mental health as an idea, how are trans and gender-nonconforming people perceived in the global mental health community? Historically, both queerness and transness have been subject to the same scrutiny and medicalization of mental illness, both globally and in Western nations. Both homosexuality and gender-nonconformity have been pathologized at different points in the history of Western psychiatry[18], the latter currently maintained as a pathology under the diagnosis of Gender Dysphoria (American Psychiatric Association 2016). In the 1960s and 70s, the gay and lesbian community challenged the categorization of homosexuality[19] as a mental disorder as described in the first two editions of the DSM. Because of this advocacy, the APA voted to remove homosexuality from the DSM in 1973, seven years prior to the publication of the DSM-III. The timing of this removal is extremely significant when considered in the context of the broad, epistemological shifts that were occurring within American psychiatric at the same time. Prior to the publication of the third edition of the DSM, psychiatric diagnoses were vaguely defined using loose psychoanalytic descriptions (Lewis 2006, 97); psychiatric practices were not ruled by diagnoses. Rather, psychiatrists focused on environmental and behavioural factors of psychological distress informed by sociology and psychoanalysis (Mayes and Horwitz 2005, 249). Wilson characterizes this shift in the organizational model of psychiatry as moving between an understanding based on the biopsychosocial model to a strictly biomedical approach (Wilson 1993, 399).

[18] While Western psychiatry and associated understandings of gender have been globalized, as previous discussed, it is important to note that some cultures, including various Native American, Indian, Bangladeshi, and Brazilian cultures, have long recognized sexual and gender variations that extend beyond the male/female binary used in the West (see Nanda 2014).

[19] Kutchins and Kirk argue that the history of the medicalization of homosexuality is "the best way to appreciate how mental disorders are invented" (Kutchins and Kirk 2003, 55).

This biomedical shift was inspired by what many have called the "crisis of legitimacy" within the psychiatric industry in the 1970s (Lewis 2006; Mayes and Horwitz 2005; Wilson 1993). Between 1900 and the 1970s, psychiatry was informed by psychoanalytic theory and treated patients using a psychotherapy approach (Mayes and Horwitz 2005, 249). Medical professionals criticized the disciplines of psychoanalysis and psychotherapy for being "too subjective, medically unscientific, and overly ambitious in terms of its ability to explain and cure mental illness" (Mayes and Horwitz 2005, 250), predicating the universalization of diagnosis. Therefore, the DSM-III sought to increase the "objectivity" of psychiatry by moving away from psychoanalysis and psychotherapy and toward "psychiatry's embrace of the disease model" (Lewis 2006, 98), revolutionizing diagnosis in the process (Lewis 2006, 98). This shift toward the disease model further solidified the medicalization of mental illness and marked the beginning of the era of "new psychiatry" (Lewis 2006, 38), which sought to base psychiatric diagnoses on systematic, theory-neutral checklists that would standardize the industry and increase its legitimacy (Mayes and Horwitz 2005, 251–52).

Regarding the development of TGNC mental health, the World Professional Association for Transgender Health (WPATH) serves as the official international governing body for TGNC physical and mental health. The association works to "promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health" (World Professional Association for Transgender Health 2018a). A major part of the WPATH's mandate to provide care and advocacy for TGNC people is through the publication of their universal *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Currently in its seventh edition, the SOC were first published in 1979 (World Professional Association for Transgender Health 2018b). The WPATH Standards of Care seek to standardize

treatment approaches to TGNC physical and mental health by providing clinical guidance to various medical professionals including doctors, psychiatrists, and psychologists, while also standardizing understandings of dysphoria and gender deviance for other professionals who often work alongside TGNC people, including lawyers, social workers, sociologists, anthropologists, sexologists, and speech pathologists (World Professional Association for Transgender Health 2018a). WPATH underscores the fact that the SOC are informed by the "best available science and expert professional consensus" (World Professional Association for Transgender Health 2018c).

WPATH's commitment to evidence-based policy recommendations are part of a broader desire for policy analysis to transform into a policy science informed by evidence-based analysis (Barker and Peters 1993; Lasswell 1970; Parsons 2002; Sanderson 2002), and the increasing enthusiasm of Western states in adopting evidence-based decisions into the policymaking process (Marston and Watts 2003, 148). The shift toward evidence-based policy making has effectively redefined public policy and the process of problem definition, by prioritizing certain types of evidence over others, and attempting to universalize the types of acceptable and unacceptable forms of evidence. However, the "meaning and practice" of evidence-based policy and the role of expert knowledges in the policymaking process have been contested (Marston and Watts 2003; Orsini and Smith 2010). Inherent to these critiques have been investigations into epistemologies and discursive power, including questions surrounding what counts as evidence and who gets to decide (see Orsini and Scala 2006; Marston and Watts 2003).

These critiques have been particularly prominent among scholars of health policy analysis, seeing as the increased interaction between medical scientists and policymakers has changed the way we understand healthcare (Boswell 2014; Orsini and Smith 2010). For example,

Orsini and Scala assert that evidence-based medicine cannot fully capture the human experience of illness necessitating the qualitative exploration of illness narratives (Orsini and Scala 2006, 109), while Feldman et al. demonstrate that positivist analyses, while allowing us to uncover the "what", often fail to uncover the "how", necessitating the use of narrative analyses in addition to positivist studies (Feldman et al. 2004, 167).

The International Classification of Diseases & the Diagnostic and Statistical Manual of Mental Disorders

Evidence-based approaches to mental health are reified in two key documents; the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders. Starting in the 1960s with the establishment of the Mental Health Programme, the WHO became "actively engaged" in aiming to improve classification and diagnostic systems (World Health Organization 1992, 2). Part of this health care project was the creation of the International Classification of Diseases and Related Health Problems, known simply as the ICD. The ICD includes statistical and epidemiological information for the classification and treatment of physical and mental illnesses at the global level (World Health Organization 2018). Though the ICD is an international document, the document is largely influenced by American and Western approaches to medicine, as it has developed over time on the input of American, Canadian and Western European advice (Clark et al. 2017, 76).

Despite being cited much less frequently than the DSM, the ICD exists to standardize[20] diagnoses and treatments for "mental disorders" (World Health Organization 2011). Published by the World Health Organization (WHO), the ICD "defines the universe of diseases, disorders,

[20] Universalization can be interpreted as an attempt to further westernized medicine through the process of globalization and/or colonize medical thought and populations in parts of the non-Western world.

injuries and other related health conditions, listed in a comprehensive, hierarchical fashion" (World Health Organization 2018). As per international treaty, all WHO member states are required to use the ICD reference system when reporting health data for ease of comparison across different states (Clark et al. 2017, 76).

The ICD-11 was recently released on June 18, 2018. While the ICD-10 categorized Gender Identity Disorder under "Mental and Behavioural Disorders", this most recent version followed through on a former promise to "downgrade" GID from a psychiatric to a sexual disorder. In the ICD-11, what was formerly classified as "Gender Identity Disorder" is now referred to as "Gender Incongruence", under section 17, "Conditions Related to Sexual Health" (International Classification of Disorders 11 2018). Gender Incongruence is defined as "a marked and persistent incongruence between an individual's experienced gender and the assigned sex" (World Health Organization 2018c).

At first, this reclassification appears to be a victory for the TGNC community, as many people who identify as trans or gender-nonconforming have long asserted that being trans or gender-nonconforming is a natural human variation, not a psychiatric disorder, and that to classify it as such generates extra, undue stigma on top of high levels of transphobia already experienced by TGNC people. The World Health Organization, seeking to respond to this problem, created a working group called the ICD Working Group on Sexual Disorders and Sexual Health to discuss the logistics of depathologization.

According to Dr. Geoffrey Reed, a psychologist who was part of the Working Group, changing the name from Gender Identity Disorder to Gender Incongruence, and labelling Gender Incongruence a sexual health condition rather than a mental health condition, was done to make

the diagnosis less stigmatizing[21] (Vagianos 2018). However, categorizing Gender Dysphoria as a sexual health condition is far from being less stigmatizing. Firstly, this new categorization incorrectly equates gender identity with sexuality, regressing achievements made over decades of TGNC activist work that has sought to disconnect these two concepts. Second, there is little difference between considering being trans or gender-nonconforming as a sexual abnormality as opposed to a psychiatric abnormality. Both classifications are equally pathologizing; categorizing "being trans" as a sexual health condition simply shifts the focus of pathologization from the body to the mind.

However not all members of the TGNC community reacted negatively to this development; many trans advocates have supported the WHO's decision, including the organization Transgender Europe (TGEU), which called the diagnostic reclassification a "historic achievement" for the WHO and the TGNC community (Fairchild 2018). In an issue statement on depathologization, published prior to the publication of the ICD-11, the TGEU proposed "the inclusion of a non-pathologising category in the ICD 11" (Fairchild 2018) to ensure access to transition related healthcare services[22]. While is it important that TGNC people have access transition related healthcare services, this right was equally defended when Gender Incongruence was classified as a mental disorder. Therefore, many TGNC people have rightfully criticized this reclassification. Trans activist Phaylen Fairchild writes:

> While many were overjoyed that the state of existing as a Transgender human being has been declassified as a mental illness, few seem to consider the damage that reclassifying us as "Sexually incorrect" will inflict upon us. Politically, it will favor those conservatives who have deemed us sexual deviants; specifically transwomen, who they claim are disguising themselves as women in order to

[21] While at the same time breaking the universal definition of Gender Dysphoria by moving away from the DSM definition.
[22] The World Health Organization has defended the maintenance of a trans-related disorder in the ICD, even as a contested sexual health disorder, by asserting that it is needed for trans health care (Telesur 2018).

> infiltrate, in some perverse, covert operation, women's public bathrooms. Religious leaders and Republicans have had a hyper-focus on the sexuality of transwomen to perpetuate the irrational fear that we are a threat to their wives and young daughters. Radical feminists have malignantly leveraged the sexuality of transwomen to accuse them of feigning womanhood with the intent of 'Forcibly penetrating lesbians by pretending to be women.' (Fairchild 2018)

To consider the shift toward a physical-sexual disorder less pathologizing than a mental disorder is a consideration that requires some unpacking. If we approach this reclassification from a critical disability and Mad studies perspective we can begin to understand how the reframing of Gender Incongruence as a sexual (physical) disability, rather than a mental or psychological disability, has been propelled by ableist assumptions about mental illnesses. The idea that physical disabilities are less stigmatizing is both a sanist and ableist statement that suggests physical disabilities are somehow more acceptable or desirable than mental or psychiatric disabilities. This idea places physical and mental disabilities in a hierarchy, creating a "race to the bottom" to see who is the most oppressed, and reinforces mind/body dualism. As argued by Pilling, the idea that queer and trans people need to be rescued from "the categorization of madness" and the associated stigma "leaves the biomedical model and all of its attending problems in tact" (Pilling 2014, 71), by framing mental illnesses negatively as defective conditions that TGNC people should never want to be diagnosed with. Not only does this increase mental health stigma, but it also marginalizes those members of the TGNC community who live with "other" forms of mental health problems, including mood, anxiety, and personality disorders, that have nothing to do with their gender identity, and/or physical disabilities.

In addition to the ICD, the Diagnostic and Statistical manual of Mental Disorders (DSM) also categorizes, codifies, and standardizes approaches to diagnosing mental health issues.[23]

[23] Unlike the ICD, which focuses on both physical and mental "diseases".

Published by the American Psychiatric Association (APA), the DSM is currently in its fifth edition (DSM-5), which, like the ICD-11, made significant changes to the way biomedicine and psychiatry approach the problem of "transness". Currently, the DSM defines Gender Dysphoria as:

> …a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender. (American Psychiatric Association 2016)

While the DSM is *the* authoritative document on mental disorders in the West, it is also the subject of great controversy. Its claims to objectivity, scientific rigor, and universality of diagnosis have been challenged largely by academics and "social commentators" (Lev 2006, 37) who claim that diagnostic categories are a form of social control and that the DSM is an inherently political document (Burstow 2015, 80). As argued by Foucault, Western diagnostic categories have "sought out human deviance with the intention of establishing institutionalized social control" (Foucault qtd. in Lev 2006, 37–38). This deviance has been based largely on the stereotypes within different categories of identity, including gender, race, ethnicity, class, dis/ability, sexual orientation, and gender identity (Lev 2006, 38). Mental health diagnoses are added, removed, and changed based on politics (Burstow 2015, 83). These changes happen in quick succession; within one month of a new manual being released, a new one has already begun to take shape (Burstow 2015, 83).

While this contradiction is problematic, it is not surprising. We should expect discourses to change; scientific discovery and social attitudes must necessarily develop. However, the rate that many of these diagnoses change leads to discursive inconsistencies across policies and

healthcare sectors, making it difficult for TGNC to navigate services that align with their personal perceptions of the relationship between their mind and body; science may not be objective, but it may certainly be objectifying in certain circumstances.

However, DSM critics remind us that these so-called "alterations" are more than minor changes to epidemiology (Burstow 2015; Mayes and Horwitz 2005). The changing nature of DSM diagnoses means that someone diagnosed with an illness may see their diagnosis removed by the publication of the next edition (Burstow 2015, 74), effectively changing their relationship with medicine and sense of self (Benson 2013, 21). The changing definitions and name of diagnoses underscores how the use of certain language within policies constructs (un)livable realities; medicalization controls the social legitimacy of new definitions of health and disability (Withers 2012, 32); any discursive changes are illegitimate until they can be reified within one of medicine's leading texts, the ICD or the DSM. These changes often occur in response to pressure from anti-psychiatry groups that challenge the psychiatrization of emotions and behaviour. Seeking to make mental health diagnoses more sensitive, however, the APA also lessens the specificity of these diagnoses, "both loosening the thresholds for existing diagnoses and introducing new disorders at the fuzzy, elastic and populous boundary with normality" (Frances and Nardo 2013, 1). Building on this assertion, Mayes and Horowitz argue:

> The paradigm shift in mental health diagnosis in the DSM-III was neither a product of growing scientific knowledge nor of increasing medicalization. Instead, its symptom-based diagnoses reflect a growing standardization of psychiatric diagnoses. This standardization was the product of many factors, including: (1) professional politics within the mental health community, (2) increased government involvement in mental health research and policymaking, (3) mounting pressure on psychiatrists from health insurers to demonstrate the effectiveness of their practices, and (4) the necessity of pharmaceutical companies to market their products to treat specific diseases. (Mayes and Horwitz 2005, 249)

Seeking to provide greater transparency, LaFrance and McKenzie-Kohr describe the DSM as a document that "offers a biomedical framing of people's experiences of distress and impairment" (Lafrance and McKenzie-Mohr 2013, 119). This definition draws attention to both the *power* of biomedicine and the *process* of framing and suggests that the DSM is a living document informed by power-imbued external forces[24] that frame, rather than objectively discover, new psychiatric diagnoses based on dominant understandings of distress and impairment. This is not to suggest that distress and/or impairment are not felt within individual bodies, as for many TGNC people, dysphoria[25] is a very real feeling of discomfort within the body. Nor am I suggesting that these phenomena are solely socially constructed. Rather, the medically coded versions of distress and impairment as socially constructed disorders may objectify psychiatrized subjects by forcing them to constantly adapt to the changing nature of their diagnoses.

An excellent example of the effect that these diagnostic shifts can have on psychiatrized subjects is the depathologization of homosexuality. In 1973, the American Psychiatric Association removed homosexuality from the DSM after a series of consultations that challenged the dominant theories of pathology, which viewed anything not "normal" as disorder, and theories of immaturity, which framed homosexual people as sexually immature and requiring medical intervention. These framings were replaced with a new theory of normalization that viewed homosexuality as "a phenomenon that occurs naturally" (Drescher 2015, 566). However, while homosexuality was removed as a diagnostic category *de facto*, many have argued that it was replaced by a "back door" diagnosis in the DSM-II: Sexual Orientation Disturbance, which

[24] While scholars like Burstow, LaFrance and McKenzie-Mohr, and Lewis frame the DSM as a socially constructed document, it is important to remember that governments, the Ontario government included, have yet to treat the DSM as anything other than an objective biomedical text. In this context of this thesis, this distinction is significant, as any mention of the DSM in "socially-oriented" TGNC mental health policies will signify a critical contradiction between rhetoric and epistemology.

[25] In this instance, I used the lower-case "d" dysphoria as a reference to the feeling, rather than the diagnosis.

referred to individuals who were “troubled about their homosexual impulses” (Kutchins and Kirk 2003, 90). This diagnosis would undergo many nominal transformations, including Dyshomophilia, Homosexual Conflict Disorder, and Ego-dystonic Homosexuality (Bayer 1981; Drescher 2015; Kutchins and Kirk 2003; Spitzer 1981). The use of different names reflects the ever-evolving nature of the DSM and underscores the pervasiveness of its attempts to pathologize behaviours under new diagnostic categories. In 1987, Ego-dystonic Homosexuality was finally removed from the revised edition of the DSM-III, the DSM-III-R, after significant pressure from gay activists and the realization that the disorder was hardly ever diagnosed in clinical settings (Kutchins and Kirk 2003, 90).

Though the 70s were a triumphant era for the lesbian, gay, and bisexual population, the same could not be said for the TGNC community. With the removal of homosexuality came the introduction of Gender Identity Disorder. Many have argued that the introduction of Gender Identity Disorder in the DSM-III was also a way for the APA to replace homosexuality as a mental disorder (Drescher 2010, 441), as “transgender people have been the most visible minority among people involved in same-sex sexual practices” (Drescher 2010, 430). Based on this understanding, it is not difficult to imagine how the shift from homosexuality to Gender Identity Disorder could be understood as a back-door diagnosis. However, it is important to consider the connotations of GID apart from its connection to the pathologization of homosexuality, not only because gender identity and sexual orientation are two different concepts, but because of the complicated nature of the diagnosis regarding access to medical transition that cisgender homosexual people did not have to consider.

In response to the inclusion of GID in the DSM-III-TR, TGNC activists mobilized to challenge its status as a mental disorder, arguing that being transgender is a normal form of

gender variation (Drescher 2010, 447). While the broad categorization of mental illness has been contested by psychiatric patients, consumers, survivors, and ex-patients (p/c/s/x), Gender Dysphoria has been cited as the most politically contested diagnosis in the DSM (Ault and Brzuzy 2009; Drescher 2010). TGNC mental health activism has largely adopted the social model of mental illness to describe the relationship between gender identity and distress, arguing that distress associated with Gender Dysphoria is caused by the limited socially constructed gender binary and the transphobia this enables (Pilling 2014, 4).

Efforts to destigmatize and demedicalize the diagnosis of Gender Dysphoria came out of this activism. The medical community's process of de-stigmatizing TGNC people was reflected in the last round of updates to the DSM in 2013, nearly 30 years after the removal of homosexuality. The DSM-V replaced the diagnosis of Gender Identity Disorder with Gender *Dysphoria*, the latter term chosen to increase accuracy of diagnosis and to lessen the stigma associated with pathologization (Fraser et al. 2010, 80). This change resulted from the consensus that being trans or gender-nonconforming is not a pathology and that "gender variant individuals are not inherently disordered; rather, the *distress* of gender dysphoria is the psychological problem" (Fraser et al. 2010, 80, emphasis added). Furthermore, many activists have adopted a social approach to this distress, identifying the distress felt by dysphoria as a "conflict between the individual and society rather than an individual's mental health" (Benson 2013, 33).

However, I question whether the shift in language has been less pathologizing when translated to the context of public policies and practices, and whether this is inherently problematic, just as the TGNC community has challenged the recent changes to the ICD diagnosis. Many have defended the maintenance of Gender Dysphoria as a diagnosis, citing it as a "medically necessary" legitimization for access to transition-related services. However,

whether the diagnosis uses the term "disorder" or "dysphoria" is largely irrelevant if the idea behind its maintenance as a diagnostic category in any form is more "medically necessary" reasons. While the diagnosis itself is less medicalized, it rationalization is firmly situated within a biomedical approach. The language of medical necessity is an artefact of universal health care insurance practices (Nye 2003, 109) and is, not surprisingly, a way to make TGNC mental health issues legible to cisgender people and doctors, perhaps crucial for visibility and service access, however ethically questionable (Lev 2006, 37). As Thomas Szasz writes, "disease threatens the individual, not society" (Szasz 1997, 19). Therefore, individuals should be able to adopt or reject whichever diagnoses they desire, whether having a diagnosis is important to help their understanding of the self, or if having a diagnosis helps legitimate access to care. However, I argue that it may be difficult for some to accept these types of approaches, as the connection between TGNC identity and mental illness is so deeply ingrained in our sociocultural psyche. While TGNC advocates and allied psychiatrists can argue that being trans is not an illness, these arguments are stacked against a history of pernicious pathologization that began with the invention of madness and the irrationalization of the sexually abnormal. To explore this problem, I now turn to Foucault's notion of biopower to demonstrate how the biopolitics of sex /gender and the biopolitics of madness interact uniquely at the site of the TGNC subject, making it hard to uncouple these two identity factors.

The Biopolitics of Sex and Gender

The biopolitics of sex are generally understood as a form of power mobilization, enacted through the control of the reproductive capacities of individuals, including health, birth, and mortality (Foucault 1978, 146–47). For Foucault, "…prevailing categories of sex identity are the result of the transition to a modern regime of power" (Foucault in Deveaux 1994, 223). This

modern regime, through the creation of categories of sexual identity and the deployment of sexuality, created what Foucault called the "sexual body" (Foucault 1978, 127), narrowly defined by medical and religious establishments. The medicalization of sexuality enabled the pathologization of homosexuality, and, as we might infer, non-normatively gendered bodies. The politicization and medicalization of sexuality and the body provided a standard upon which normality could be based; facilitating the pathologization of deviation from social norms in the form of mental illness. For example, women who were not deemed able or willing to care for children (read as women who were not able to fill their rigidly defined reproductive role) were subsequently hystericized and institutionalized in psychiatric hospitals, as they were deemed unfit and undesirable for reproduction, therefore useless for the cultivation of the body politic (Foucault 1978, 147). Similarly, we can understand how the pathologization of TGNC people has been facilitated in this same way; non-normative gender identities subvert dominant, Western cultural systems of gender, sexuality, and reproduction[4]. Gender and sexuality, while different, are inherently linked. Dominant understandings of reproduction are based on the cisnormativity of heterosexual relationships; it is gender difference is what underlies the "homo/hetero" distinction (Stryker 2014, 39). Broadly speaking, gender is taken up by all members in a society to fulfill a social organizational purpose; "one cannot be a subject without an identity, so identity is tied into the productive power of ideology" (Ferguson 2016).

I focus on the biopolitics of sex as having two main consequences; (1) scripting TGNC bodies and (2) creating sex-reassignment surgery as a form of state-endorsed compulsory heterosexuality and gender-legibility. While both consequences are linked to one another, scripting precludes the enforcement of gender legibility and must therefore be discussed in isolation. For Stryker, TGNC bodies exist at the margin of biopolitical power. They "exceed or

elude capture within the gender apparatus" and "defy the logic of the biopolitical calculus" (Stryker). I disagree with Stryker's assertion, arguing that TGNC bodies have long been under the control of biopower; however, it was not their cultivation, but rather their eradication, that has been most beneficial to modern forms of power.

Foucault tells us that ideological, religious, and scientific expertise convene at the site of the body (Foucault in Stryker 2014, 39). These different authoritative powers work to produce different social and political discourses to construct subjective ideas of personhood as "innate and ontologically given" (Stryker 2014, 39). This understanding of biopower helps us understand how trans and gender-nonconforming bodies, through policy discourse, become political sites of debate over power, culture, and social values. TGNC bodies are politically threatening to the binary gender order (Stryker 2014, 40) necessitating political control through self-governing apparatuses such as psychology and psychiatry. Biopower therefore helps us to understand the extreme political consequences that mental health policies have on TGNC subjects. The power that the state, and the integration of biomedicine and the psydisciplines into state power, has in determining what counts as a pathologized gender expression is a form of biopower that relies on an assumption of biology and the alignment of gendered behaviour with physical and biological sex. It should be noted that biopower manifests itself in many different forms. There are numerous practices, both political and social, that seek to turn TGNC bodies into "docile bodies" (Deveaux 1994, 224), which, in this context, can be done through the pathologization of Gender Dysphoria, enabling psychiatric disciplining, or sex reassignment surgeries and hormone treatments that realign gender diverse bodies with dominant conceptualizations of gender. Without delegitimizing the very real benefits associated with medical gender transition, mental health policy discourses script the idea of a universal TGNC subject, as discussed previously in

my discussion of global mental health discourses. This universal TGNC subject is one who is disconnected between mind and body; to cure the mind, one must cure the body. This body/mind disconnect is part of the script that TGNC people are often forced to repeat in doctors' offices as a ticket to care, even though they harmfully reinforce the idea that dysphoria is a disorder of the mind, equating neurobiology with selfhood or "brainhood" (Vidal 2009), while simultaneously asserting that bodies are ontologically certain and exhibit the "natural" form of gender expression. This is not to suggest that policies governing dysphoria are mere instruments of government control, designed to be inherently oppressive and reinforce heterosexuality and gender legibility. To make such an argument would be to dishonour the history of trans activism that has led to the increased accessibility of transition-related services and to deny the agency of individuals who seek out and benefit from these services. However, as Tremain reminds us, "disciplinary practices enable subjects to act in order to constrain them" (Tremain 2006, 187). Therefore, these types of policies can be read as constraining, particularly as they fail to reference gender-nonconforming, genderqueer or non-binary people, assimilating them under the trans umbrella. Even within the TGNC community, the subject of transitioning is a debated concept. For some nonbinary folks, transmen and transwomen reinforce the gender binary by "fully crossing over". These same folks argue that "real transness" can only be experienced through subversism, or the "the practice of extolling certain gender and sexual expressions and identities simply because they are unconventional or nonconforming" (Serano 2014). The practice of subversism is designed to disrupt the role of the trans subject, which is:

> To display stereotypical physical markers for scrutiny, to supply a scripted narrative of transsexuality or transgendering, and to submit to the most intrusive questions about our bodies and what we have done or want to do with them. All this further forces the outside observer's sole power to assess the trans subject's

> true sex/gender and confirms the belief that cissexuality and transsexuality are readable and readably distinct. (Enke 2012, 75)

The idea that trans people must break the boundaries constructed by the gender binary follows a logic similar to the logic of social model of disability by claim that society is viewed as the source of oppression and that the TGNC subject must alter their way of living to subvert the social order. However, I question whether the practice of subversism is possible in a society that so closely links the concepts of gender and madness. Can individuals truly subvert these health and gender categorization while also avoiding the biopolitical consequences associated with modern forms of governance? In the following section, I demonstrate how the unique historical, discursive trajectories of the biopolitics of sex and the biopolitics of madness have led to the coupling of TGNC identities and mental illness. I argue that biopower has made the uncoupling of these two categories extremely difficult and that this has impacted efficacy of subversism, and by extension, the social model of TGNC mental health.

Biopolitics of Madness

Writing on the construction of madness as a social problem, Foucault asserts that our contemporary understanding of madness has been constructed through various forms of religious, social, and political power (Foucault 1973). In *Madness and Civilization*, Foucault traces the historical development of what we know today as "mental illness", from ancient Greek understandings of "madness" to "psychiatric pathology" (Foucault in Leoni 2013, 85). Foucault demonstrates how the rise of positivist science after the Enlightenment marked a discursive shift from madness to mental illness, granting psychiatry the epistemological authority on questions of psychological difference (Foucault 2011, 109). The shift to institutionalized forms of health care

is part of what Foucault considers a characteristic of biopower, with the asylum being one of the primary forms of institutional control and disciplinary power (Foucault 1973, 63–64). While mental health care has been largely deinstitutionalized and asylums are no longer the institutional centre of control over Mad bodies, psychiatrists and other medical professionals still hold most of the epistemological control over what constitutes a mental disorder and the associated treatment protocols. Additionally, the prevailing categories of sex, male and female, normalize cisgender bodies, facilitating the pathologization of transgender, non-binary, and gender non-conforming bodies. I argue that it is for this reason that we find the majority of TGNC mental health policies to be focused on Gender Dysphoria and gender transition. The normalization of sanity and cisgenderism are facilitated by biomedical, scientific discourses, and therefore must be aligned to be perceived as non-pathological. While many TGNC people cite their experiences of dysphoria as an embodied (see Baril 2015; Serano 2009), the ontological primacy of the body, forwarded by biomedical discourses, often leads to the pathologization of the mind. As the mind cannot be seen, it is more easily understood as misaligned or "unwell" based on biological and physicals "truths".

The consequences of this incongruous pathologization have psychological impacts for TGNC people. For example, the connection between dysphoria and mental illness leads to the invisibilization of mental health problems unrelated to trans identity, including various anxiety and mood disorders. However, when these disorders are discussed in relation to TGNC people, they are talked about in isolation of the general population, linking these mental health problems again to experiences of dysphoric distress or transphobia. These engagements deny individual experiences of distress and embodiment unrelated to dysphoria, transphobic trauma, cisnormativity, or other forms of violence, reinforcing the victim or "unhappy queer" narrative

that is often applied to the LGBTQ community overall (Ahmed 2010, 89). The construction of TGNC mental health as inherently caused by social injustices and inequalities erases the identities of TGNC people who may identify as having a diagnosable mental illness that they believe best explained by a medical model of mental illness, and which cannot be explained by social factors.

At the beginning of this chapter, I asked: What is global mental health? How did the idea of "global" mental health originate? Which actors control discourses of global mental heakth? Where do TGNC subjects fit in this universalizing approach to mental health care? How have the biopolitics of gender and the biopolitics of madness uniquely influenced modern understandings of TGNC mental health? Having explored these questions, I turn now to the province of Ontario, Canada, in which we see many of these global discourses played out, albeit in different ways. The following chapter contains my empirical textual analysis, addressing Fairclough's value of interpretation in critical discourse analysis (Fairclough 2013, 21). The Ontario case is one of the most interesting to analyze, as the policy is, perhaps deceptively, quite progressive on paper. Not only has the shift to deinstitutionalization in Ontario claimed to improve mental health care overall; Ontario's sex reassignment surgery policy is evidently the most "lenient" in the country. Yet, as my analysis in the following chapter will reveal, inconsistencies in policy language have considerable positive and negative effects on the ability for TGNC people to navigate the mental health care system and their own gender identities.

Chapter 3: TGNC Mental Health Policies and Practices in Canada and Ontario

The previous chapter revealed that there is no universal definition or approach to mental health or mental health policy, despite efforts to universalize mental health diagnoses. Definitions of trans and gender-nonconforming mental health vary across psychiatric documents, demonstrating inconsistencies at both national and international levels of governance. While this inconsistency is to be expected, given the number of institutions, NGOs, and stakeholders groups that define and govern trans and gender-nonconforming mental health, the consequences of these discursive contradiction remains to be explored.

I begin this chapter by presenting an overview of the federal structure of mental health policy in Canada and the history of mental health policy and infrastructure development in Ontario from the 1950s onward. I highlight key policies at both the federal and provincial levels, including *Changing Directions, Changing Lives* (2012), and *Open Minds, Healthy Minds* (2011). Following this overview, I outline the sex reassignment surgery policy in Ontario in comparison to the rest of the provinces and territories. Next, I turn to the results of my empirical analysis and address the answers to my three initial research questions, which are as follows: How is mental health framed in institutional policies and practices in Ontario that govern TGNC mental health and/or Gender Dysphoria? What type of subjects do these policies and practices create? How might we challenge the medical/social model dichotomy regarding Gender Dysphoria and TGNC adults?

In relation to my first research question, two significant findings emerged. Firstly, most policies analyzed are not firmly situated within a singular discursive approach to mental health; many adopt language attributable to both biomedical and social models of mental illness. While it should be expected that policy-makers the adopt a multi-pronged approach to social problems,

these discursive inconsistencies raise questions as to how TGNC people navigate mental health care systems.

Regarding my second research question, I argue that the multiplicity of mental health policy discourses creates numerous TGNC subjects, who are often simultaneously framed as both sick and not sick, but often still "unwell". This contradictory phenomenon occurs within policies that have seemingly attempted to shift their language towards a more social approach, but which fail to fully disengage with biomedical language. For example, some policies will state that Gender Dysphoria, or "being trans" is not a mental illness, but the anxiety and depression experienced by TGNC people because of their gender identity are "real illnesses" requiring medical intervention. Others, including the "APA Guidelines for Psychological Practice With Transgender and Gender Nonconforming People" assert that gender variation is "healthy and normative" (American Psychological Association 2015, 835) but that individuals who are gender diverse still require "treatment" or "medical intervention" (American Psychological Association 2015, 842). While some TGNC people desire treatments or medical interventions, the use of biomedical language within socially-framed policy documents raises questions about the efficacy and propriety of single-model approaches to TGNC mental health, as well as how mental health policies and practices may best integrate nuanced discursive approaches to mental health.

Second, policies that adopt socially-oriented discourse are not necessarily congruent with a social approach to mental health based on the social model of disability. For example, many policies analyzed incorporate the Social Determinants of Health (SDoH) into their analysis of mental health problems, yet, except for a few notable examples, these policies fail to incorporate the SDoH in a way that successfully challenges the disabling nature of society. Rather, these policies frame the social determinants as problems that affect individuals, and which individuals

must adapt to through engaging on an individual basis with psychiatry or psychology. In the case of TGNC mental health, transphobia and cisnormativity are only addressed insofar as they may contribute to mental health problems; addressing the problems of transphobia and cisnormativity in society is not part of the solution. Rather, policies seek to provide new guidelines and standards of care for psychiatrists and psychiatrists to help TGNC people talk about their experiences with transphobia and other forms of discrimination, including racism, homophobia, and transmisogyny, stripped from their social context.

Finally, I argue that the inconsistencies in mental health care discourse trouble the debates surrounding the medical/social divide in trans studies and call into question the usefulness of the models of disability in categorizing approaches to TGNC mental health as the theoretical boundaries that delineate disability models do not necessarily translate well in practice. To challenge these theoretical boundaries, and to open new possibilities for engagements with biomedicine, I introduce Pamela Moss' concept of perching, which proposes that individuals can engage with biomedicine while remaining critical of its practices (Moss 2016, 223). I argue that this model can help make sense of not only discursive differences and the ineffectiveness of the medical/social theory dichotomy but can also help reveal the ineffective of the binary male/female and body/mind binaries that are integral to maintaining these contradictory framings of TGNC mental health. Before addressing these questions, however, I first present an overview of mental health care policy in Canada and Ontario to contextualize my analysis.

Federalism and Mental Health Policy in Canada

Canada is a decentralized federation, meaning that the division of powers is shared between the federal and provincial governments. While health care policy is under provincial jurisdiction, the federal government is still able to exercise a considerable amount of power over the development of provincial health policies. Because the federal government is hesitant to intervene and legislate in provincial matters, non-governmental, arms-length organizations have taken on the role of defining mental health at the federal level. In this section, I introduce two of these organizations, the Canadian Mental Health Association (CMHA) and the Mental Health Commission of Canada (MHCC).

The Canadian Mental Health Association is a nongovernmental organization that operates through hundreds of local branches across the country. While the national website does not include any reference to the specific mental health needs of TGNC people, CMHA Ontario has developed an informational document entitled "Lesbian, Gay, Bisexual, Trans & Queer identified People and Mental Health" (CMHA Ontario 2018). This grouping of TGNC people with lesbian, gay, and bisexual people problematically conflates gender identity with sexual orientation, erasing the unique social stressors and barriers to adequate mental health care for TGNC people. However, this document does highlight issues that are unique to the TGNC community, including the impact of discrimination when trying to access housing, employment, and health or social services (CMHA Ontario 2018). The document also states that "77% of trans respondents in an Ontario-based survey had seriously considered suicide and 45% had attempted suicide" (CMHA Ontario 2018).

The Mental Health Commission of Canada (MHCC) is a federally-funded organization that "leads the development and dissemination of innovative programs and tools to support the

mental health and wellness of Canadians" (Mental Health Commission of Canada 2018). The MHCC plays a role in the development of federal, provincial, and territorial mental health policy and is explicit in their commitment to including the input of people with lived experience of mental illness to ensure their goal of improving mental health for all Canadians. However, who is included in the definition of "all" Canadians, is up for debate, as the following section will demonstrate. The MHCC's commitment to including diverse voices of people with lived experiences of mental illness evidently falls short when it comes to prioritizing the voices and understanding the needs of TGNC people in Canada.

Changing Directions, Changing Lives: Mental Health Strategy for Canada

One of the most significant contributions of the Mental Health Commission to Canadian mental health policy has been its role in the development of the first federal mental health strategy, *Changing Directions, Changing Lives: Mental Health Strategy for Canada*. These federal guidelines "have been written into provincial health plans, hospital accreditation standards, and annual objectives of psychiatric departments and community organizations" (Park et al. 2014, 1). *Changing Directions* is a collaborative project, informed by the knowledge and experiences of people living with mental illness, their families, and mental health service providers (Mental Health Commission of Canada 2012, 2). Issues relating specifically to TGNC people are summarized in a two-page section called "Priority 4.5" (Mental Health Commission of Canada 2012, 92). The first half of the priority talks about the differences between men and women[26]:

[26] Whether this definition includes transmen and transwomen is unclear. However, due to the explicit identification of "transgender, transsexual, and two-spirit" people in the following section on sexual orientation, I believe it can be been assumed that the reference to men and women in this definition refers only to cisgender individuals.

> The different ways that gender makes a person vulnerable to mental health problems and illnesses mean that the impact of gender needs to be considered in prevention and early intervention efforts. (Mental Health Commission of Canada 2012, 92)

The Strategy uses the terms "men" and "women" when referring to gender in Priority 4.5, reducing gender to a binary, sex-based categorization, excluding the possibility for non-binary identities. This essentialization and exclusion is harmful as the unintelligibility of non-binary identities means that non-binary people are not seen as belonging to a future where their mental health is prioritized. Furthermore, the exclusion of non-binary people from this policy discourse erases the unique challenges that non-binary people face in relation to their gender identity and the effects of living in a cisnormative society that may cause emotional distress.

Excluded from discussions of gender, TGNC people are instead "lumped in" with issues of sexual orientation. The section on sexual orientation asserts that:

> Mental health service providers must be mindful not to stereotype or discriminate against LGBT people because of their sexual orientation, and to also recognize the impact that discrimination and stigma can have on an LGBT person's mental health. (Mental Health Commission of Canada 2012, 92)

In this case, the "T" In LGBT is meant to stand for "two-spirit", "trans-gender" and "trans-sexual" identities (Mental Health Commission of Canada 2012, 92), lumping these diverse identities into a single category, while simultaneously and erroneously labeling them as sexual orientations. The Strategy states that sexual orientation stigma affects "two-spirit, trans-gender, and trans-sexual people" (Mental Health Commission of Canada 2012, 92). While trans and gender-nonconforming people may identify as non-heterosexual, the conflation of gender identity with sexual orientation demonstrates a critical misunderstanding of these two social categories. By failing to distinguish between gender identity and sexual orientation, the Strategy

fails to consider how TGNC people may be impacted differently stigma, harassment, and discrimination, essentializing the identities of TGNC subjects.

Pilling has argued that the state-produced approach to mental health in *Changing Directions* is incongruent with the lived experiences of people living with mental health issues, especially for queer and trans people (Pilling 2014, 167). They argue that despite the Strategy's commitment to a social approach to psychological distress, the policy fails to consider how the problems of homophobia and transphobia[27] contribute to psychological distress in queer and trans people (Pilling 2014, 167). However, the framework for the Strategy, entitled *Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada* (2009) states that "mainstream approaches to mental health – which typically focus on individual symptoms and disorders – often ignore these social, political, and historical contexts" (Mental Health Commission of Canada 2009, 50). Evidently, the commitment to recognizing the social, political, and historical dimensions of mental illness have been identified as a priority in the process of developing *Changing Directions, Changing Lives*. Within other parts of the Strategy, these dimensions are explicitly recognized. Therefore, it is particularly significant that the social, political, and historical dimensions of mental illness are absent from Priority 4.5. While this omission was not necessarily a cognizant choice, the absence of these considerations affects further applications of Priority 4.5 in other policy areas.

Mental Health in Ontario

The development of mental health policies and practices in Ontario has largely followed the same trajectory as federal strategies; mental health care policy in the provinces is also largely

[27] I would include cisnormativity in this list.

defined by arms-length organizations. Wiktowicz argues that this political strategy developed due to the failure of governments to come to an agreement on how to proceed with the development of community-based mental health care services following the deinstitutionalization of mental health care in the province (Wiktowicz 2008, 387).

Although *Changing Directions, Changing Lives* is a federal mental health strategy, the policy has been streamlined into provincial mental health policies and programs in Ontario. The province currently spends $3.7 billion annually on mental health care, most of this funding dedicated to addressing issues in children and youth (Ontario Ministry of Finance 2017). In March 2018, the Wynne Liberal government announced that an additional $2.1 billion will be invested in mental health care over the next four years "to rebuild Ontario's mental-health system"[28] (Giovannetti 2018). Policies, practices, and political decisions that are specific to Ontario which will be discussed in this section are *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, the process of deinstitutionalizing mental health care in the province, as well as the introduction of TGNC mental health considerations as a public health issue and the subsequent development of the official Ontario policy on sex-reassignment surgery.

Ontario's official mental health and addictions strategy, *Open Minds, Healthy Minds* (2011) offers "a comprehensive approach to transforming the mental health system through a clear mission, forward-thinking vision and long-term strategies for change" (Ontario Ministry of Health and Long-Term Care 2011). This strategy is similar in both mission and content to the federal mental health strategy, *Changing Directions, Changing Lives*. The goal of *Open Minds, Healthy Minds*, is to promote mental health and well-being, create resilience, develop prevention

[28] This policy is subject to change under the new Conservative government led by Doug Ford.

and early intervention strategies, and provide timely, "human-integrated" services (Ontario Ministry of Health and Long-Term Care 2011). While there is no mention of the relationship between mental health/illness and gender in the Ontario strategy, the use of prevention and resilience narratives has negative implications for TGNC people, prevention narratives especially. The idea that Gender Dysphoria could be prevented could potentially justifying harmful psychological practices, including conversion therapy. The idea that other forms of mental illness can be prevented, such as anxiety or depression, puts onus on individuals to seek out medical care for problems that are often, but not necessarily, socially constructed within cisnormative and/or transphobic social and political environments.

The Shift to Deinstitutionalized Mental Health Care in Ontario

Prior to the 1950s, the primary providers of mental health services were Provincial Psychiatric Hospitals (PPHs), funded by the federal government (Hartford et al. 2003, 66). PPHs were preferred over general hospitals, as they were eligible for federal funding, and had more beds and specialized services. Although, like most hospitals, PPHs were chronically overcrowded and understaffed (Hartford et al. 2003, 66). In 1959, Dr. Matthew Dymond, the Ontario Minister of Health introduced a proposal for a shift to community-based care, along with the establishment of more psychiatric units in general hospitals (Hartford et al. 2003, 66). The rhetoric surrounding the shift to community-based care was focused on limiting the need for patients to leave their communities for hospital treatment, on the basis that this form of care would be less "restrictive and disruptive" (Hartford et al. 2003, 57). Community-based care is defined as any care that is performed outside of a hospital setting (Canadian Mental Health Association Ontario 2016). This definition largely references traditional forms of treatment, such

as outpatient psychotherapy, but also extends to include other forms of services and support, such as "health promotion, illness prevention, crisis response, outreach, case management, housing and employment support (Canadian Mental Health Association Ontario 2016).

While the shift to community care is symptomatic of a broader move toward decentralization in Canadian governance (Hartford et al. 2003, 65), what enabled mental health decentralization in particular was a larger series of actions relating to mental health governance, both inside and outside government. The Schizophrenia Society of Ontario presents the story of deinstutionalization from the perspective of civil rights activists and psychiatric patients/consumers/survivors/ex-patients (p/c/s/x) in challenging the mandate of institutional care. The Schizophrenia Society writes that the Canadian civil rights movement "raised concerns about the state's intervention into the lives of persons with mental illnesses and promoted the right to self-determination" (Schizophrenia Society of Ontario 2013, 26). During this time, the idea that mental illness could be understood as a social construct, rather than an objective biomedical problem, began to rise on the level of public consciousness, enabling civil rights and mental health activists to challenge the role of hospitals in incarcerating and treating individuals with mental illnesses (Schizophrenia Society of Ontario 2013, 26).

Numerous scholars have written about the harms of institutionalized mental health care (Burstow 2015; Chesler 2005; Foucault 1973; Ussher 2013). For example, Bonnie Burstow has written about the monopolistic power granted to biomedicine in providing "care" to mad people, starting in the eighteenth century (Burstow 2015, 34). During this time, mad people were subject to ongoing surveillance and were often subject to "terror, silence, humiliation, darkness, pain, and solitary confinement" (Burstow 2015, 34) as forms of treatment. Women and other marginalized groups have often borne the brunt of these abuses and have been historically more

likely to be incarcerated in psychiatric institutions (see Chesler 2005; Ussher 2013). Even today, psychiatric institutions are overwhelmingly perceived by Mad scholars as sites of coercion and control, rather than care. Burstow writes,

> The object of hospitalization is to correct or keep in check what is seen as wrong. In practice that means discouraging certain behavior, encouraging other. A good part of the inmate's life inside, correspondingly, is being told what to think and do, moreover, being rewarded for good behavior (called getting "privileges") and punished for bad (sometimes called "sanctions," sometimes called "treatment"). In essence, the inmate is being treated like a child, generally a recalcitrant one, with the institution as all-knowing parent. (Burstow 2015, 120)

Knowing this history, the shift in Ontario mental health policy from institutionalized care to community-based care appears, at its surface, to be a positive development, although many have written about the failures of the deinstitutionalization process (Anthony 1993; Bassuk and Gerson 1978; Isaac and Armat 1990; Shimrat 2013a). Community mental health care is not always a better form of care, nor does it erase medicalized approaches to psychological distress (Shimrat 2013b, 144). In Ontario, the available types of community care range from pseudo-institutional "Mental Health Club Houses" to long-term care facilities and Community Mental Health Care Teams (Shimrat 2013b, 144). In these cases, the threat of re-institutionalization was used as a form of coercive control to ensure non-disruptive, non-violent behaviour (Shimrat 2013b, 144). Ultimately, this reveals that community-based care is still imbued with hierarchies of power that are exercised over people who engage with mental health care services.

The move toward deinstutionalization and the pervasiveness of power dynamics in community care have additional implications for TGNC people. While community-based forms of care and support are available for TGNC people with "real illnesses" (Bauer et al. 2009), such as anxiety or depression, receiving a diagnosis of Gender Dysphoria and/or accessing transition-

related services is not something that can be addressed in community care settings. While therapeutic support during the transition process can be offered through community programs, the prescription of hormones and surgeries are two main services linked to TGNC mental health that must be conducted in institutionalized settings. Therefore, this shift towards deinstitutionalization has created yet another divide within the TGNC community; subjects sometimes straddle the boundary between community-based and institutionalized services, which vary in both nature and quality of care.

While transition-related medical services change the physical appearance of TGNC people's bodies, the negative psychological impact of dysphoric feelings often leads to "real" mental health problems that are, in most cases, ameliorated post-transition (Lawrence 2003; Wierckx et al. 2011). Therefore, transition-related medical services can be understood as an integral part of *mental* health care services for TGNC people. In this way, TGNC people experience mental health care systems differently than cisgender people, as many are forced to seek help from institutionalized medicine to physically transition and alleviate feelings of distress caused by dysphoria. In Ontario, transition-related medical services can only be accessed and funded with the professional support of a doctor, psychologist, nurse, or social worker (Ontario Ministry of Health and Long-Term Care 2016), the majority of which work within institutional settings, namely the Sherbourne Health Centre, which has a dedicated LGBTQ health program, and the Centre for Addictions and Mental Health (CAMH), the primary mental health care facility in Ontario.

Accessing Sex Reassignment Surgery in Ontario

TGNC people living in Ontario who seek to medically transition are forced to comply with the guidelines established by the Ontario Ministry of Health and Long-Term Care. This

policy is aligned with "internationally-accepted standards of care for gender dysphoria" (Ontario Ministry of Health and Long-Term Care 2016) as established by WPATH. The explicit reference to the WPATH definition, rather than the DSM, connects this policy to international policy discourses, demonstrating how discourses often transcend hierarchical boundaries.

Compared to the rest of Canada, the Ontario sexual reassignment surgery (SRS) policy is the least restrictive in three major areas: services offered, funding, and referrals. Table 1 presents an overview of the regulations for SRS in each Canadian province and territory, demonstrating the varying degrees of gatekeeping and the (de)mobilization of expert knowledges.

Table 1. Sex Reassignment Surgery Policies by Canadian Province

Province	Services	Funded?	Who can refer?
Newfoundland*	--	n/a	n/a
Nova Scotia	SRS, HRT, counselling	yes	physician, specialist, or health care professional trained in WPATH SoC
New Brunswick	SRS, HRT	yes	Physician, nurse, or mental health professional
PEI	Some SRS	yes	physician
Quebec	SRS	yes	need psychiatrist and doctor (+ doctor who is prescribing hormones)
Ontario	SRS, HRT	yes	doctor, nurse, psychologist, or social worker
Manitoba	Bottom surgery[29] only	yes	/
Saskatchewan	SRS, HRT	yes	psychiatrist

[29] Phalloplasty or vaginoplasty.

Alberta	Bottom surgery only	yes	list of 5 specific doctors
BC	Most SRS	yes, but not travel expenses for other services	/
Yukon*	--	n/a	n/a
NWT*	--	n/a	n/a
Nunavut	n/a	no	n/a

* Gender-confirming medical services not available, but surgery not needed to have ID gender marker changed

The Ontario SRS policy enables TGNC people to have access to both surgery and hormone replacement therapy (HRT). Referrals are not limited to certain physicians, like Alberta, or psychiatrists only, as in Saskatchewan. The Ontario policy does not even require the referring physician, nurse, or social worker to be trained in the WPATH SOC as is the case in Nova Scotia. Ontario does not require more than one referral, as does Quebec. On paper, the SRS policy in Ontario appears to be the most "lenient" or "progressive", which is interesting for two reasons. Firstly, it demonstrates a clear shift toward improving access to SRS (and HRT), which is a positive development for many TGNC people. However, this apparently leniency can potentially be wielded negatively. Being the best makes it easy to defend staying stagnant until other provinces catch up. Furthermore, what appears to be progressive on paper can be harmful in ways that have not been considered alongside the negative aspects of progressive changes in Ontario mental health care. For example, the option to interact with a nurse of a social worker presents TGNC people seeking "treatment" with the option of engaging with someone lower down in the psychiatric hierarchy, however, it still involves authoritative engagement. However, if the end goal for a trans or gender-nonconforming person is to receive sex-reassignment surgery, they must eventually engage with institutional (surgical) medicine. Evidently, the developments in Ontario mental health care have not benefitted all Ontarians equally. Access to

community care is a privilege for cisgender people or for TGNC people who do not experience dysphoria and/or do not seek to transition physically.

Method

Using the models of mental illness as theoretical guides, I have performed a critical discourse analysis of a select number of policies and practices in Ontario pertaining to queer, TGNC-specific, or general mental health problems. Knowing that TGNC mental health literature is dominated by the medical and social models, I sought to identify both medical and socially-based language to test whether this discursive divide exists in practice in policy contexts. Evidence of medicalized discourse within a policy was signaled by the appearance of specific terms, including "recovery", "treatment", "prevention", "illness", or "disorder", as classified within Burstow's terminology chart (see Appendix A). In this chart, Burstow also argues that medical language is often the same as governmental language. Many of these medical/governmental terms can be found within the policies and practices analyzed, although some alternatives to these terms that are not listed in Burstow's terminology chart can also be found, suggesting that there are counter-discourses working alongside the biomedical model of mental health.

Situating certain policies within a social approach to mental health was a less precise process. Burstow's chart (see Appendix A) does not include a list of terms that would denote a social approach. Rather, she lists "refusal" terms to challenge the governmental, biomedical vocabulary. These refusal terms come from Mad studies and the Mad pride movement. These terms were not used to measure a social or alternative approach to the biomedical model for two reasons: (1) refusal language is not necessarily socially-based language – the language often uses

reclaimed terms that have historically been oppressive, such as "mad" and "crazy", and (2) this language is community-specific and has not yet made it into the vocabulary of governments or alternative movements. Mad studies approached to mental health largely reject biomedicalization, as the Mad pride movement from which it originated has historically adopted an anti-psychiatry approach to mental health.

Mental Health Policy Discourse in Ontario

As evidenced in Table 2 (see below), most policies and practices I have analyzed do not neatly fit within the binary categories of biomedical and social. Perhaps most notably, strictly medical approaches appear to have largely disappeared from the political landscape.

Table 2. Mental Health Policies and Practices in Ontario

Policy	Organization	Discursive Theme
Mental Health Act	Government of Ontario (1990)	Biomedical
Sex Reassignment Surgery	Ontario Ministry of Health and Long-Term Care (2017)	Biomedical
Creating Together: Developing a Mental Health and Addictions Research Agenda for Ontario: LGBT Consultation Summary	Creating Together, Rainbow Health (Bauer and Schiem 2015)	Social
Joint Statement on the Affirmation of Gender Diverse Children and Youth	Canadian Association of Social Workers (n.d.)	Social
Changing Directions, Changing Lives: The Mental Health Strategy for Canada	Mental Health Commission of Canada (2012)	Mixed
Guidelines for Psychological Practice With Transgender and Gender Nonconforming People	American Psychiatric Association (2015)	Mixed
Lesbian, Gay, Bisexual, Trans & Queer Identified People and Mental Health[30]	Canadian Mental Health Association Ontario (2017)	Mixed

[30] Not an official governmental policy; rather, a policy recommendation.

Mental Health Services for Gender-Diverse and Sexual-Minority Youth	Canadian Mental Health Association Ontario	Mixed
Counselling and Mental Health Care of Transgender Adults and Loved Ones[31]	Trans Care Project (2006)	Mixed
Feedback on the regulatory amendment regarding access to Insured Transition-Related Surgeries in Ontario	Rainbow Health Ontario and Sherbourne Health Centre (n.d.)	Mixed
Mental Health and Primary Care Framework	Centre for Addiction and Mental Health (2016)	Mixed
Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy	Government of Ontario (2011)	Mixed
Realizing the Vision: Better Mental Health Means Better Health	Ontario's Mental Health and Addictions Leadership and Advisory Council (2017)	Mixed
Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People[32]	World Professional Association for Transgender Health (2011)	Mixed
Transgender People in Ontario, Canada: Statistics to Inform Human Rights Policy	Trans Pulse Project (2015)	Mixed

Biomedical Policies

Only two policies fit into what I would consider a purely biomedical approach to mental health: the Ontario Mental Health Act (1990), and the Ontario Ministry of Care and Long-Term Health's Sex Reassignment Surgery Policy. The overwhelming biomedical discourse of the Mental Health Act can largely be attributed to its age; although Ontario mental health policy began shifting towards less institutionalized models in the mid-1960s, the social model of disability didn't gain traction until the mid-1970s (Oliver 2013, 1024). Furthermore, psychiatrized people have historically existed outside or separate from the disability movement

[31] This document was written as part of Vancouver's Trans Care Project but is also available on the Rainbow Health Ontario website as part of their educational materials and is therefore included as a part of Ontario TGNC mental health policy recommendations.

[32] The World Professional Association for Transgender Health (WPATH) is an American-based organization but is included in this study as the Ontario Ministry of Health and Long-Term Care has adopted the WPATH Standards of Care policy (Ontario Ministry of Health and Long-Term Care 2017).

(Withers 2012, 102). The first model to consider both "social and psychological events on the one hand, and to factors affecting physical health on the other" as factors contributing to mental health not did not originate until 1992 (Goldberg and Huxley 1992). The second biomedically dominant policy, Ontario's Sex Reassignment Surgery policy, adopts WPATH's definition of Gender Dysphoria, as explored in the previous chapter. The policy notes that Gender Dysphoria is a *medical* term (Ontario Ministry of Health and Long-Term Care 2016). The use of the term Sex Reassignment Surgery, rather than Gender Reassignment Surgery or Gender-Confirming Surgery is another factor that signifies a dedication to utilizing medicalized language, as the notion of "sex", rather than gender, is an inherently medicalized concept, linked directly to biology and asserted in most medical spaces to ontologically primary. While these two policies are the primary documents that frame mental health and TGNC overall, they are often contradicted by policies and practices that challenge the medicalization of mental health, or which use both medically- and socially-oriented language when talking about mental health. One area of mental health care governance in Ontario that does not neatly fit within a medical/social is the field of social work, which I explore in the following section.

Social Work and Social Approaches to TGNC Mental Health

Despite appearing to be more concerned with the "social", as evidenced by its name, social work has increasingly become the target of disability studies' critical gaze. Critical disability scholars have asserted that social work has long been associated with "medicalised paradigms of intervention" (Meekosha and Dowse 2007, 169), which has understandably led the disability and Mad communities to question and reject its practices. Yet, the Canadian Association of Social Workers' "Joint Statement on the Affirmation of Gender Diverse Children

and Youth" adopts a uniformly *social* discursive approach, challenging this assertion. This discourse has the potential to be misleading, however; what exists in policy (and theory) does not always exist in practice. Like policies that adopt the social determinants of health, social work's use of socially-oriented discourse can also be constructed as performative.

As Nick Mulé argues, social work approaches to LGBTQ populations tend to reinforce heteronormative, cisgender ideals (Mulé 2015, 4). As part of the non-profit sector, social work tends to cater to the normative social order, falling victim to what Mulé calls the non-profit industrial complex, which has traditionally failed LGBTQ communities (Mulé 2015, 17). However, the Joint Statement appears to depart from these mainstream ideals[33], urging social workers to affirm the identities of gender-diverse youth. The statement recognizes that traditional gender roles are "a reflection of sexist, racist, heteronormative and cisnormative assumptions" that must be challenged within the social work profession (Canadian Association of Social Workers n.d.).

While this progression is a positive development, there are inherent limitations to this document specifically, and social approaches to TGNC mental health more broadly. For example, the Joint Statement only applies to social workers who provide services to children and youth. While better attention and care to the needs of TGNC youth is greatly needed, progressive social work must extend to TGNC people of all ages. Furthermore, it addresses affirmation only on an individualized, therapist-to-client basis, doing little to challenge mainstream transphobic attitudes that have the potential to affect the mental health of individuals. Social work, in its focus on the individual, fails to recognize the nuanced relationship between body and mind, focusing on "helping individuals, families, groups and communities to enhance their individual

[33] The Joint Statement lists York University Professor Nick Mulé as a contact for more information on the recommendations. Mulé's contributions to the document likely contributed to its progressive nature.

and collective well-being" by addressing social issues such as "poverty, unemployment, and domestic violence" (Canadian Association of Social Workers n.d.). Therefore, more "holistic" approaches to TGNC mental health are needed; the biomedical and social models present disabled people with limited choices for engagement. Policies that adopt one singular approach over the other inherently set limits on those who will identify with their approach, therefore limiting the effectiveness of their resources. Individuals are forced to choose, can be ostracized by their communities – within the TGNC community, there is a strong opposition to psychiatry and biomedical approaches to gender non-nonconformity, which leads to the stigmatization of individuals who decide to engage with biomedical institutions.

Evidently, a new approach is needed, not only to better reflect the unique, diverse experiences and identities of the TGNC community, but also to preserve the agency and freedom of those who have been marginalized by the subversism movement within the TGNC community. Therefore, the idea that mixed discourse policies exist is an exciting idea. Indeed, community-based TGNC mental health research points to the need for medical, social, and other forms of support. However, as I will demonstrate, "mixed discourses" are not always more progressive; there is a difference between policies that explicitly claim this approach, and others that claim social approaches but use medicalized language.

For example, *Open Minds, Healthy Minds*, Ontario's mental health and addictions strategy, recognizes that "social injustices" contribute to mental *illness*, a medicalized term, but then switches to using the terms mental *health* and mental *wellness*, terms which are often adopted in opposition to "mental illness" to challenge the medicalization and pathologization of madness (Burstow 2013, 83). Within mixed-discourse policies like *Open Minds, Healthy Minds*, it was evident that certain policies have a strong discursive bias; some were overwhelmingly

medical, with occasional use of socially-oriented language, while others were overwhelmingly social, with the occasional use of medicalized language. The latter were the most common type of mixed-discourse policies overall. The only biomedically-dominant mixed-discourse policy was *Realizing the Vision: Better Mental Health Means Better Health*.[34] Socially-dominant policies included *Changing Directions, Changing Lives* (2012), *Open Minds, Healthy Minds* (2011), and the "APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" (2015).

The APA Guidelines exist to assist psychologists in providing "trans-affirmative psychological practice" to TGNC people (American Psychological Association 2015, 832). The Guidelines adopt a minority stress model approach to TGNC mental health care, recognizing that many TGNC people experience mental health problems because of the way society treats these individuals. The document is designed to provide psychiatrists and psychologists with the language and knowledge to properly engage with TGNC people in their practice in an affirmative way. The use of the word "treatment" is this document is used to refer to future actions, meaning that the overwhelmingly social approach adopted within this document is part of a medicalized process the aims to treat the individual. While treating individuals is not an inherently medicalized process, and individualized therapy programs are often quite helpful, they are only helpful insofar as they teach individuals to adapt to their circumstances and do little to change the oppressive conditions that may have led people to therapy in the first place. Individualized care ideologies "locat[e] the harm entirely within individual human body-minds, operating as if each person were their own ecosystem (Clare 2017, 15).

[34] This finding was quite surprising to me personally, based on the dominance of biomedical discourse and critiques of the biomedical model in psychiatric and trans studies literatures and my own assumptions.

Furthermore, these policies, while using both medical and social language in their approaches to TGNC mental health, also fail to use socially-oriented language in a way that would be congruent with a social model of disability. For example, most policies that adopt a fully or partially social approach to mental health reference the Social Determinants of Health (SDoH). The Public Health Agency of Canada defines the SDoH as social factors that "influence the health of populations" (Public Health Agency of Canada 2016), including gender, culture, education, and employment. However, while certain policies cite the social determinants as key contributors to "mental illness", the proposed policy solutions rarely address these social problems directly. Continuing with the example of the APA Guidelines, this document recognizes that social factors, including harassment and poverty, affect the mental health of TGNC people, but support an individualized therapy model to address these problems. In this case, addressing distress and/or trauma becomes the responsibility of the individual, even if the source of the distress and/or trauma is caused by an external, socio-economic factor, such as transphobic harassment or discrimination. This is not to deny the importance of individualized therapy programs for many people; we know that access to therapeutic services is important for TGNC people and that working towards TGNC-affirmative approaches is a much-needed advancement in the psy disciplines. However, putting the onus on individuals to adapt to their oppressive circumstances, without working towards a more major sociocultural shift is not a sustainable solution to TGNC mental health problems. Furthermore, therapy is often, paradoxically, unattainable due to socio-economic barriers that are disproportionately experienced by TGNC people, particularly transfeminine people and TGNC people of colour (see Gehi and Arkles 2007).

Ideally, the solution for mental health problems should include a combination of both social and medical intervention factors. One such approach is the informed consent model. This model of care recognizes that TGNC mental health is a complex problem and individuals know their needs best. Informed consent approaches to TGNC mental health and transition do not fully antagonize the medical model or medicalized approaches to TGNC mental health care; rather, the model aims rejects the "burden of gatekeeping" (Deutsch 2012, 146) that delays, or sometimes prevents, TGNC people from transitioning. While gatekeeping is part of the biomedical approach to mental health and gender transition, gatekeeping is not exclusive to biomedicine; gatekeeping theory has been used to explain information management and power relations in the context of other political, social, economic, and cultural institutions, including news media.

The key characteristic of any form of gatekeeping is control of information (Shoemaker and Vos 2009, 1). Regarding TGNC mental health and gender transition, while TGNC folks can access information about services online, or from their primary care physicians, the mobilization of information (diagnoses, referrals) is attributed solely to medical professionals in Ontario; policies and practices in Ontario have yet to adopt informed consent models. Informed consent approaches to TGNC mental health and gender transition do not demand rejection of biomedicine or medical approaches to health care necessarily; rather, these types of approaches seek to disrupt the hierarchy of decision-making power in attaining care, even within biomedical systems.

In summary, while certain policies adopt social approaches to mental health, the individual is ultimately problematized or pathologized, meaning that these policies, while using the language of the social, are not situated within a social model of disability. This argument is

supported Pilling in his analysis of *Changing Directions, Changing Lives* and the LGBT population. Pilling argues the adoption of the SDoH framework:

> "does not advance a strong structural analysis of the role of discrimination and oppression in shaping experiences of mental distress, access to services, and recovery and does little to acknowledge the role of the state in perpetuating or alleviating this oppression. (Pilling 2014, 173)

This failure to interrogate the role of structural oppression in the context of mental health is indicative of a trend in Western psychiatry. For example, Burstow cites the testimony of a psychiatric nurse who stated the following in an interview:

> When psychiatric nurses branch out and start to create their own models, there are lots of creative models that take into account the social determinants of health, quality of life, but when the rubber hits the road, the default is right there" (Burstow 2015, 160)

Ontario policies are no different; these same responsibilization narratives are present in many of the Ontario policies I have analyzed, even within overwhelmingly socially-oriented policies. For example, the CAMH Primary Care Policy Framework states, "social determinants of health can impact ability to access high-quality primary care" (Centre for Addictions and Mental Health 2016). Here, the SDoH are conceived as a barrier to participating in dominant, individualizing mental health care systems; the solution to mental health problems remains within biomedical forms of care, not social transformation. Similarly, The Public Health Agency of Canada and the *CAMH Primary Care Guidelines* (2016) both cite poor self-regulation habits as social determinants of mental health, which is an inherent contradiction to the meaning of the word "social" (both focus on the individual "self"). Furthermore, the Public Health Agency of Canada identifies poverty, unemployment, and lack of social support as factors that can contribute to

poor mental health outcomes, yet also cite alcohol and tobacco use, unhealthy diet, and "poor self-care" as social factors (Public Health Agency of Canada 2016). These latter classifications pathologize individual behaviour and choices rather than interrogating the underlying social factors that contribute to these behaviours, such as poverty or unemployment — which the Agency already references — rendering these individual pathologizations redundant.

Similarly, Canada's federal mental health strategy, *Changing Directions, Changing Lives*, fails to define what is meant by "social determinants" in the opening policy statement. While the policy later expands on the definitions of the social determinants by exploring the health effects of poverty, unsafe housing, and food insecurity (Mental Health Commission of Canada 2012, 6), this section is incongruent with the understanding of the SDoH presented in the introduction, as these problems are not addressed with a corresponding strategy to tackle these health barriers. Overall, this policy does nothing to ameliorate the problems of the social determinants of health. Of course, issues such as housing, poverty, and food security are addressed in other areas of social policy in Canada and Ontario. However, the division between these types of policies is problematic as it suggests that these issues are not fully integrated – mental health is still the realm of doctors treating individuals who are affected by society, and that it is the responsibility of individuals to seek out this help and adapt to oppressive social systems.

What we learn from these framings of the social and the adoption of the social determinants of health is that these socially-oriented policies, while they use the term "social", do not fundamentally perform the values of a social model of disability or mental illness. What is not said is that the problem is framed as though individuals' reactions to these social determinants are the problem. Consequently, it is not difficult to understand why many policies

still frame individual mental health problems as pathological and necessitating medical interventions. Evidently, social considerations are still largely on the periphery; governments recognize that access to housing matters for emotional and psychological wellbeing but remain unable to move beyond individual models of treatment, care, and/or cure. The distinction between socially-oriented policies and a true adoption of an approach situated within a social model of mental illness is evidenced in the following quote by Lindsey Graham. Graham argues:

> The social factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution. This distinction is important because, despite better health and improvement in health determinants, social disparities persist… More emphasis on social inequalities is required for a determinants-oriented approach to be able to inform policies to address health inequalities. (Graham 2004)

This confusion between social factors and underlying social causes is evident in both the *CAMH Primary Care Guidelines* and *Changing Directions, Changing Lives*. For example, poor self-care can undermine the health of individuals, but it is the underlying social processes, and unequal distribution of wealth, that contribute to poor self-care which may lead to mental health problems. But to frame poor self-care as a factor contributing to mental health problems reproduces the cycle of pathologization, framing individuals as the problem, rather than society at large. While both approaches address different needs of mentally ill TGNC people, the conflation of individual (biomedical) and social models within policies, in the absence of a clearly stated nuanced, or "compound" strategy, arguably affect the provision of mental health services in Ontario, meaning that TGNC people across the province may not receive equal standards of, or approaches to, care. TGNC people who see a social worker may be met with a

very different approach to mental health and/or transition from their primary care doctor, who may adopt a completely different approach to their psychiatrist.

Knowing that problematic discursive inconsistencies exist, what can be done to move forward? How can we bridge the gap between the medical and social models of TGNC mental illness within the dominant literature? How can we reconcile the performativity and navigational confusion of mixed-discourse policies? Critical disability and Mad studies are not sufficient in this case, ultimately because the two main models don't fully capture the lived experienced of TGNC people. As mentioned in chapter two, some disability scholars, including Alison Kafer and Alexandre Baril, have proposed alternative or "third way" models to approaching disability, models that have been designed to move beyond unitary approaches and encapsulate queer and trans realities. However, as discussed in my theoretical framework, I desire to turn to another alternative model, Pamela's Moss' perching, as I believe that perching is both an excellent theoretical and *practical* strategy that can help TGNC people navigate mental health services as they are currently designed.

Perching

Perching is "a practice of positioning oneself within biomedicine while maintaining a critical view of it" (Moss 2016, 223). Unlike the social model and other "third way" approaches (see Baril 2015; Kafer 2013) perching affords agency to individuals who must necessarily engage with biomedicine in the "here and now". Because funding and access to gender-confirming surgeries is regulated by the acquisition of Gender Dysphoria as a medical diagnosis (Government of Ontario 2017), some TGNC people are forced to accept pathologization, often in contradiction with their personal beliefs and values. Others, of course, welcome, or even seek out these diagnoses for validation. Perching rejects the idea that engagement with biomedicine is an

inherently oppressive and disempowering interaction. In the experiences of patients with ME, perching on the edge of biomedicine presented opportunities where patients could "challenge one's own oppression, marginalization, and powerlessness through micro-instances of the exercise of power" (Moss 2016, 229). As Moss asserts, "subjects produced through the discursive and material elements of biomedicine do not have to reproduce the existing set of relations" (Moss 2016, 227).

The social model, nor any other model of disability, can accurately address the problem of medicalization without first understanding what exactly is being medicalized. While biomedicine and biopower have real effects on subjects and have historically oppressed populations that have existed on the margins of society, individuals and communities are increasingly working together to find their voices and push back against these oppressive systems. It is increasingly possible to engage with historically oppressive structures without being co-opted, as proponents of the social model have suggested. This is not to argue that institutionalized biomedicine does not need to be reformed, nor do I wish to suggest that everyone is able to exercise their agency when engaging with biomedicine in the same way. I recognize that the ability to self-advocate successfully is often inherently linked to resource access, including economic recourses to obtain private therapy or transition-related services and community support, which for some TGNC people, particularly those in small towns, may not have available to them.

This does not mean, however, that the way mental health policies and practices are framed do not affect the lived experiences of TGNC subjects. As I explore in the following section, mental health discourses do impact the lives of subjects, but I do not believe that the

social model is the only helpful alternative perspective to those who reject biomedicine, nor do I believe that biomedicine is always oppressive.

Biopower and the Creation of (Un)livable Realities

Biopower provides us with a helpful theoretical framework through which we can analyze the consequences of policy discourses and framing processes. In this section, I seek to answer two questions using biopower as a theoretical guide. What are the consequences of discursive inconsistencies in mental health policies and practices in Ontario? How can we reconcile these convoluted framings? In this section, I return to, and build upon, my discussion of the biopolitics of sex and madness in chapter two. I argue that medical and social approaches to mental health have become assigned to the body and mind, respectively, through the sex/gender distinction that associates medicine with the sexed body and society with the gendered mind, via the unique historical trajectories of sex/gender and madness as biopolitical projects. If we construct the inability to detach gender identity from mental illness because of the unique relationship between the biopolitics of sex/gender and the biopolitics of madness, it becomes easier for us to imagine how biomedical and social discourses become intertwined, and, in some cases, masquerade as the other.

Furthermore, I argue that biopower, while concerned with power over bodies, is an ultimately disembodied theory and is problematic when attempting to explore the framing of TGNC mental health as embodiment is entwined with mental distress. While Foucault understands the body as the product of social discourse – as an object or victim of discursive power – I argue that biopower affords too little agency to individuals to determine the

circumstances of their lives.[35] While analyzing TGNC mental health through a biopolitical lens helps us make sense of the impact that the types of policy discourses outlined in my empirical analysis have on the formation of political subjects, it is important that we do not reduce TGNC people to docile subjects of biomedicine; TGNC people are anything but "docile". The effects of biopower are neither inevitable nor irreversible. In suggesting that this power is inevitable, we reduce already marginalized populations, such as the TGNC community, to passive victims who will inevitably face violence when engaging with mainstream institutions and who will have little agency in challenging those who seek to define the circumstances of their own lives. When we share these narratives over and over, we potentially ostracize those who need or want biomedical validation for their symptoms or suffering.

Bill Hughes argues that Foucault's conceptualization of the body as docile "underestimates the body's role as subject [and] as an agent of self- and social transformation" (Hughes 2005, 79). Paired with Moss' perching model, which argues that medical subjects can also exercise decision-making power in the pursuit of care and/or cure, Hughes' critique of biopower demonstrates that while the oppressive forces of biopower certainly do have an impact on the lives of TGNC subjects, they are not doomed to live under the oppression of biopower or biomedicine.

This idea that TGNC people must reject engagement with biomedicine is part of a larger problem within critical disability studies; the separation of disability, distress, and impairment. This separation has resulted in an oppressive discourse within both disability studies and Mad studies, one that tends to prioritize the social model as a catch-all approach to challenging biomedicine and curative violence. In challenging social oppression, social approaches to

[35] As do critics of the medical model.

disability/madness appear to have forgotten that disability is only one source of oppression experienced by disabled people. Madness, too, and the associated internal, distress, is a self-oppressive force that many people experience as am embodied phenomenon. The pathologization of the mind, while predicated on the assumption of an incongruent body, leaves out considerations of the body altogether, as evidenced by trans activist Julia Serano's account of her experiences with the delegitimization of her identity. Serano writes:

> … the people in my life who voiced the strongest objections invariably stressed that what I was experiencing was simply "all in my head." […] Their arguments relied on the presumption that my physical anatomy—my male sexed body—was the only relevant, unalterable reality, and that what was going on in my mind—my female gender identity—was unreal and illegitimate by virtue of its invisibility. Of course, this is the opposite of what I actually experienced: The feeling that I had had since childhood that there was something wrong with me being male, and that I should be female, was very real and very unalterable, whereas my physical body has proven to be quite malleable in comparison. But their belief that my external, anatomical sex is most relevant and immutable essentially rendered my inner experience, my mental state, as irrelevant and unstable. (Serano 2009, 5)

Serano's testimony highlights an important reality of trans experience that is not often reflected in mainstream policy discourses. When policies speak of TGNC mental health, particularly Gender Dysphoria, there is the overwhelming assumption that the source of distress is located within the mind. However, as Serano demonstrates, some TGNC people identify their bodies as sites of distress or as being deviant from an ontologically certain mind. Here, the concept of "bodymind" is useful to our theorizing. Expressing disability using the concept of bodymind is an approach to trauma and disability studies that challenges Cartesian body/mind dualism through the assertion that "mental and physical processes not only affect each other but also give rise to each other" and that they "tend to act as one, even though they are conventionally understood as two" (Price 2015, 269).

Bringing the Body Back In: Towards a TGNC Theory of "Bodymind"

The concept of bodymind has recently been taken up by feminist, queer, and critical disability studies scholars, primarily as a way of communicating that mental disability matters, but also as a reminder that the body and questions of embodiment are often at the margins of critical disability theory, despite its focus on physical disability. I adopt the term "bodymind" to challenge not only Cartesian mind/body dualism, but also the association of sex with the body and gender with the mind; I equate body/mind dualism with the sex/gender distinction. While sex is attributed to physical and biological features including genitals, hormones, and sex organs (the body), gender is generally understood to refer to one's identity (the mind). As argued by West and Zimmerman, what we know as normative, non-pathological gender is socially and discursively constructed, both external to and separate from the biochemical processes of the body. Gender is something that people do; "an ongoing activity embedded in everyday interaction" (West and Zimmerman 1987, 130). This perspective contrasts with scientific understandings that equate sex with gender and which see these categories as temporally fixated. The authors also recognize that while there is a difference between sex and gender, the two are not always congruent (West and Zimmerman 1987, 132). This recognition that sex and gender do not always align within a single binary interpretation has been used to explain the existence of trans and gender-nonconforming people; if gender is socially constructed, it is possible to identify as a gender that is incongruent with the sexed body. Yet, in recognizing this difference, the body is less frequently cited as the source of discomfort or non-normativity.

I use Margaret Price's definition of bodymind in this project. Rather than essentializing mind and body into a single phenomenon, Price adopts the term bodymind to re-center psychiatric impairment within critical disability analyses. I use the term bodymind to achieve the

opposite, challenging the attribution of mental illness as a sole phenomenon of the mind by drawing attention to experiences of trans embodiment and debility. In doing so, I am not simply proposing an argument that mental illness has physical, embodied elements. While I know this to be true as a mad person, what I aim to challenge is the idea that "trans distress" is a psychological problem, as opposed to a problem with the body. I do not wish to assert that bodies are essential, biologically determined, or epistemologically certain. Rather, I adopt a phenomenological approach to the body that validates experiences of embodied distress and extends beyond the socially constructed, disciplinary consequences of biopower. I assert that biopower does not only have consequences for social bodies and challenge the idea that discursive power is the main source of oppression for gendered/mad bodies. In relying on the idea of a *social* body (Foucault 1978, 140), Foucault overlooks the significance of embodiment and the potential transformative power of harnessing experiences of embodiment to challenge the seemingly inevitability of biopower. Disability cannot be reduced to the "disembodied play of discourse" (Hughes 2005, 81). I critique, as Hughes' does, Foucault's understanding of political subjects as "docile bodies" (Hughes 2005, 80) or helpless victims of discursive power. If we focus too much on the social consequences of disability/oppression, we risk further solidifying biopower (control over bodies).

However, while the concept of bodymind helps us think through differing approaches to Gender Dysphoria that focus solely on the body or solely on the mind, bodymind can go too far by eliminating the body/mind distinction altogether. While some cultures view body and mind as unitary, eliminating the difference would delegitimize individual TGNC claims to bodily, rather than psychological distress, and vice-versa. By separating mind and body, TGNC people are often forced to prioritize, or to accept the pathologization of, one aspect of their identity; mind or

body. For many TGNC people, this can lead to the destruction of self-hood and force policy-scripted relational identity, as the prioritization of mind or body within policies can create artificial hierarchies and ostracize individuals like Julia Serano, who do not see their relationship with their bodymind reflected in policy language. Furthermore, while some TGNC people like Serano identify the source of their distress as existing within their bodies, rather than their minds, this does not mean that policies that shift trans-related disorders from mental to physical disorder categorizations are any more progressive, as exemplified by the recent changes made to the ICD discussed in chapter two.

How then, can we advance a perspective that recognizes bodymind without losing sight of the primacy of the body? Perching, again, provides a useful tool to help understand how individuals can straddle two seemingly oppositional concepts; just as Moss asserts that individuals can engage with biomedicine while remaining critical of it, I would assert that TGNC individuals can consider their dysphoria to be a "mental illness" located within the mind, while simultaneously remaining critical of the connotations of this distinction, Similarly, I also argue that TGNC individuals can assert that the source of their distress is located within their body, rather than their mind, while also recognizing the psychological effects that this distress creates. Furthermore, it is also possible for TGNC individuals to consider their dysphoria as effecting both body and mind, and that their psychological distress manifests in an embodied form. The diverse nature of these experiences are not the problem. Rather, the problem is that these nuanced approaches to mental health, identity, gender, body, and mind have not been accurately captured within policy discourse.

To conclude, the question remains whether the adoption of these nuanced experiences are compatible with an institutionalized approach to mental health governance. While I have argued

in chapter two that community mental health care services are not always available to meet the diverse mental health needs of TGNC individuals, it is evident that governmental mental health care services are not able to meet the diverse needs to the TGNC community either. In my conclusion, I explore a series of questions that this research has generated, and which future researchers may be interested in answering, including the question of whether this focus on public policy as a site of subject formation and care is too limiting.

Conclusion

As trans and gender-nonconforming people become more visible in society, individuals and institutions alike have had to adapt to new social values, assumptions, and behaviours. At the global, federal, and provincial levels, numerous organizations dedicated to the rights and welfare of TGNC people have proliferated since the mid-1990s, including the World Professional Association for Transgender Health, the American Psychiatric Association's Task Force on LGBT Issues, and the inclusion of queer and trans-specific sections of major mental health policies and organizations in Canada, including *Changing Directions, Changing Lives,* and the Canadian Mental Health Association. However, not all policies are able to address the "problem" of TGNC mental health equally. In this thesis, I have attributed the difficulty of defining TGNC mental health to the unique relationship between TGNC minds and bodies and the unfortunate reality that mental health policies and practices in Ontario are overwhelming stuck on legislating the mind.

In this thesis, I sought out to ask three main questions: How is mental health framed in institutional policies and practices in Ontario that govern TGNC mental health and/or Gender Dysphoria? What type of subjects do these policies and practices create? How might we challenge the medical/social model dichotomy regarding Gender Dysphoria and TGNC adults? I answered these questions by integrating insights from critical disability studies, Mad studies, and trans studies, urging for a greater interaction among these three disciplines. It is my hope that by bringing these literatures together, I have been able to address the question of "what is the problem represented to be" (Bacchi 2012) more accurately than previous studies that have tried to understand TGNC mental health through singular medical or social models. The purpose of exploring policy problem definitions using critical discourse analysis has been to get to the root

of problem understandings; when we understand a problem based on the discursive context of a policy, rather than by its mere linguistic content, we gain a better understanding of the problem at hand, generating new, more accurate possibilities to help address the problem.

In this thesis, I have argued that mental health policies and practices in Ontario are not firmly situated within a singular discursive approach to mental health and that these inconsistent framings need to be more explicit in their understanding of different approaches to mental health. I argue that the most inclusive policies allow individuals to engage with mental health care services based on their personal understanding of their psychological distress, whether the source be biochemical, social, political, economic, or any combination of factors. Unfortunately, the nature of "mixed discourse policies" do not reflect a nuanced understanding of the relationship between biomedical and social factors of mental illness, as social approaches appear performative, and medicalized language remains predominant, even within "socially-oriented" policies.

Secondly, I have argued that the multiplicity of mental health policy discourses creates numerous TGNC subjects, who are often simultaneously framed as both sick and not sick, and individuals who are "not sick" may still be unwell. The coupling of sex and gender with madness has made this shift away from a model of sickness difficult; the idea that being trans was a mental illness, and therefore treatable through medical intervention, is what made trans and gender-nonconforming people legible in our cisnormative society.

To address my third research question, I used the concept of perching (Moss 2016) to challenge the divisions between those who support the medical model of TGNC mental health and those who oppose this model through social understandings of mental health. I have demonstrated that the social model is a very limiting model, using the work of Kafer and Baril.

Therefore, rather than advocate for a different, "third way" approach to theorizing TGNC mental health, it is important to provide ways of navigating policies as they currently are. To address this need, I have used Moss' concept of perching to argue that TGNC subjects do not have to reject biomedicine to be a "good" subject, despite what some in the community might suggest. TGNC people, while certainly marginalized within society and the field of medicine, still possess agency. As Moss argues, it is possible to engage with biomedicine while remaining critical of it (Moss 2016, 223).

In this thesis, I have also sought to contribute to the field of policy studies to expand its purview beyond traditional political theories to include critical disability and Mad perspectives. I have sought to examine the intersection of mental health and TGNC issues within the realm of public policies and practices. In analyzing mental health policies and practices in Ontario, I have uncovered the contradictory nature of the discursive approaches to both mental health and gender identity and have discussed the consequences of these contradictions using Foucault's notion of biopower.

While the TGNC community has come a long way in terms of visibility and acceptance, there are still many policy changes that need to happen to better support the needs and respect the rights of TGNC people, mental health being one of them. As this thesis demonstrates, TGNC mental health is poorly theorized; policymakers have sought to include TGNC people as a target audience for carbon-copy, highly medicalized policy frameworks that were established long before TGNC people were seen as a specialized, and deserving, target population. Policymakers owe it to the trans and gender-nonconforming to get these issues right. Yet, as these policies currently stand, many of them are unable to address the diverse needs of the TGNC population and their mental health. While I have argued that adopting a perching strategy can be helpful for

TGNC people navigating these confusing (and somewhat disabling) mental health care systems, it is my hope that my work demonstrates the need for robust. critical policy analysis. Future researchers may be interested in exploring how policymakers may address discursive problems within mental health policies and practices but may also challenge the efficacy and propriety of legislating mental health, and/or TGNC subjects overall.

Appendix A. Burstow's (2013) Terminology Chart

Medical Term	Government Term	Reclaimed Term	Refusal Term
Committal	Committal		Incarceration
Depressed	Depressed		Sad/low energy
Diagnosis	Diagnosis		Label
Eletroconvulsive therapy	Eletroconvulsive therapy		Shock
Hallucination			Hearing or seeing what others do not see or hear
Hospital, psychiatric facility	Hospital, psychiatric facility	Loony bin	Psychoprison
Medication, psychiatric medication	Medication, psychiatric medication		Psychiatric drugs
Mental disorder, mental illness, mental disability	Mental disorder, mental illness, mental disability	Disability	A way of being or processing that psychiatrists do not see as "normal"
Mental health	Mental health		Sense of well-being
Mentally ill, mentally disordered	Mentally ill, mentally disordered	Mad, lunatic, psycho, crazy, nutter	Troubled, having emotional problems, having problems in living, having a spiritual crisis
Mental patient, psychiatric patient	Consumer, consumer/survivor, user	Madman, Madwoman	Psychiatric survivor, psychiatric inmate, "patient"
Recovery, remission	Recovery, remission		Feeling better; alternatively, recently acting in a way psychiatrists prefer
Suicidal ideation	Suicidal		Thinking of killing self
Symptoms	Symptoms		Ways of being or coping that others find problematic, sometimes also the person themselves
Treatment	Treatment		Intervention/assault

Works Cited

Ahmed, Sara. 2010. *The Promise of Happiness*. Durham: Duke University Press.

American Psychiatric Association. 2016. "What Is Gender Dysphoria?" Accessed January 7, 2018. https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

American Psychological Association. 2015. "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People." *American Psychologist* 70 (9): 832–64. https://doi.org/10.1037/a0039906.

Anthony, William A. 1993. "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s." *Psychosocial Rehabilitation Journal* 16 (4): 11.

Ault, Amber, and Stephanie Brzuzy. 2009. "Removing Gender Identity Disorder from the" Diagnostic and Statistical Manual of Mental Disorders": A Call for Action." *Social Work* 54 (2): 187–189.

Bacchi, Carol. 2012. "Introducing the 'What's the Problem Represented to Be?' Approach." *Engaging with Carol Bacchi: Strategic Interventions and Exchanges*, 21–24.

———. 2016. "Problematizations in Health Policy: Questioning How 'Problems' Are Constituted in Policies." *SAGE Open* 6 (2): 1-16.

Bacchi, Carol, and Joan Eveline. 2010. "Approaches to Gender Mainstreaming: What's the Problem Represented to Be?" In *Mainstreaming Politics: Gendering Practices and Feminist Theory*, edited by Carol Bacchi and Joan Eveline, 111–38. Adelaide: University of Adelaide Press.

Baril, Alexandre. 2015. "Transness as Debility: Rethinking Intersections between Trans and Disabled Embodiments." *Feminist Review* 111 (1): 59–74.

Barker, Anthony, and B Guy Peters. 1993. *The Politics of Expert Advice: Creating, Using, and Manipulating Scientific Knowledge for Public Policy.* Pittsburg: University of Pittsburg Press.

Bassuk, Ellen L., and Samuel Gerson. 1978. "Deinstitutionalization and Mental Health Services." *Scientific American* 238 (2): 46–53.

Bauer, Greta R., Rebecca Hammond, Robb Travers, Matthias Kaay, Karin M. Hohenadel, and Michelle Boyce. 2009. "'I Don't Think This Is Theoretical; This Is Our Lives': How Erasure Impacts Health Care for Transgender People." *Journal of the Association of Nurses in AIDS Care* 20 (5): 348–61.

Bayer, Ronald. 1981. *Homosexuality and American Psychiatry: The Politics of Diagnosis*. Princeton University Press.

Bechard, Melanie, Doug P. VanderLaan, Hayley Wood, Lori Wasserman, and Kenneth J. Zucker. 2017. "Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A 'Proof of Principle' Study." *Journal of Sex & Marital Therapy* 43 (7): 678–88.

Benson, Kristen E. 2013. "Seeking Support: Transgender Client Experiences with Mental Health Services." *Journal of Feminist Family Therapy* 25 (1): 17–40.

Beresford, Peter. 2004. "Madness, Distress, Research, and a Social Model." In *Implementing the Social Model of Disability: Theory and Research,* edited by Colin Barnes and Geof Mercer, 208–22. Leeds: The Disability Press.

Bockting, Walter O., Michael H. Miner, Rebecca E. Swinburne Romine, Autumn Hamilton, and Eli Coleman. 2013. “Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population.” *American Journal of Public Health* 103 (5): 943–51.

Blue. 2018. “It Wasn’t Like They Said: When Dysphoria Doesn’t Fit the Script.” *Medium*, July 15. https://medium.com/@AzureFemme/it-wasnt-like-they-said-when-dysphoria-doesn-t-fit-the-script-5f64b5131fb0.

Borrell-Carrio, F., Anthony L. Suchman, and Ronald M. Epstein. 2004. “The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry.” *The Annals of Family Medicine* 2 (6): 576–82.

Boswell, John. 2014. “‘Hoisted with Our Own Petard’: Evidence and Democratic Deliberation on Obesity.” *Policy Sciences* 47 (4): 345–65.

Burstow, Bonnie. 2013. “A Rose by Any Other Name: Naming and the Battle against Psychiatry.” In *Mad Matters: A Critical Reader in Canadian Mad Studies*, edited by Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 79–90. Toronto: Canadian Scholar’s Press Inc.

———. 2015. *Psychiatry and the Business of Madness: An Ethical and Epistemological Accounting*. New York: Springer.

Canadian Association of Social Workers. n.d. “Joint Statement on the Affirmation of Gender Diverse Children and Youth.” Accessed June 18, 2018a. https://www.casw-acts.ca/en/joint-statement-affirmation-gender-diverse-children-and-youth.

———. n.d. “What Is Social Work?” Accessed July 9, 2018b. https://www.casw-acts.ca/en/what-social-work.

Canadian Mental Health Association Ontario. 2016. “CMHA Ontario 2016 Pre-Budget Submission.” https://ontario.cmha.ca/wp-content/uploads/2016/08/CMHA-Ontario-Pre-Budget-Submission-2016-1.pdf.

Cavanaugh, Timothy, Ruben Hopwood, and Cei Lambert. 2016. “Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients.” *AMA Journal of Ethics* 18 (11): 1147–55.

Centre for Addictions and Mental Health. 2016. “Mental Health and Primary Care Policy Framework.” https://docplayer.net/38240960-Mental-health-and-primary-care-policy-framework.html.

Chesler, Phyllis. 2005. *Women and Madness*. New York: Palgrave Macmillan.

Clare, Eli. 2017. *Brilliant Imperfection: Grappling with Cure*. Duke University Press.

Clark, Jocalyn. 2014. “Medicalization of Global Health 2: The Medicalization of Global Mental Health.” *Global Health Action* 7 (1): 1-6.

Clark, Lee Anna, Bruce Cuthbert, Roberto Lewis-Fernández, William E. Narrow, and Geoffrey M. Reed. 2017. “Three Approaches to Understanding and Classifying Mental Disorder: ICD-11, DSM-5, and the National Institute of Mental Health’s Research Domain Criteria (RDoC).” *Psychological Science in the Public Interest* 18 (2): 72–145.

Clements-Nolle, Kristen, Rani Marx, Robert Guzman, and Mitchell Katz. 2001. “HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention.” *American Journal of Public Health* 91 (6): 915-21.

Clements-Nolle, Kristen, Rani Marx, and Mitchell Katz. 2006. “Attempted Suicide among Transgender Persons: The Influence of Gender-Based Discrimination and Victimization.” *Journal of Homosexuality* 51 (3): 53–69.

CMHA Ontario. 2018. “Lesbian, Gay, Bisexual, Trans & Queer Identified People and Mental Health.” Canadian Mental Health Association: Ontario. 2018. http://ontario.cmha.ca/documents/lesbian-gay-bisexual-trans-queer-identified-people-and-mental-health/.

Conrad, Peter. 1992. “Medicalization and Social Control.” *Annual Review of Sociology* 18 (1): 209–32.

Cooper, Sara. 2016. “Global Mental Health and Its Critics: Moving beyond the Impasse.” *Critical Public Health* 26 (4):

Crow, Liz. 1992. *Renewing the Social Model of Disability*. University of Leeds.

Davis, Lennard J. 2016. *The Disability Studies Reader*. London: Routledge.

Deutsch, Madeline B. 2012. “Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics.” *International Journal of Transgenderism* 13 (3): 140–46.

Deveaux, Monique. 1994. “Feminism and Empowerment: A Critical Reading of Foucault.” *Feminist Studies* 20 (2): 223-47.

Dewey, Jodie M., and Melissa M. Gesbeck. 2015. “(Dys) Functional Diagnosing: Mental Health Diagnosis, Medicalization, and the Making of Transgender Patients. *Humanity & Society* 41 (1): 37-72.

Dijk, Teun A. van. 1993. “Principles of Critical Discourse Analysis.” *Discourse & Society* 4 (2): 249–83.

Drescher, Jack. 2010. “Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual.” *Archives of Sexual Behavior* 39 (2): 427–60.

———. 2015. “Out of DSM: Depathologizing Homosexuality.” *Behavioral Sciences* 5 (4): 565–75.

Ellis-Petersen, Hannah. 2017. “BBC Film on Child Transgender Issues Worries Activists.” *The Guardian*, January 11, 2017. https://www.theguardian.com/society/2017/jan/11/bbc-film-on-child-transgender-issues-worries-activists.

Engel, George L. 1977. “The Need for a New Medical Model: A Challenge for Biomedicine.” *Science* 196 (4286): 129–36.

Enke, A. Finn. 2012. “The Education of the Little Cis: Cisgender and the Discipline of Opposing Bodies.” In *Transfeminist Perspectives in and beyond Transgender and Gender Studies*, edited by Enke, A. Finn, 60–80. Philadelphia: Temple University Press.

Fairchild, Phaylen. 2018. “From Bad To Worse: World Health Organization Reclassifies Transgender As a Sexual Health Condition.” *Medium*, June 26, 2018. https://medium.com/@Phaylen/from-bad-to-worse-world-health-organization-reclassifies-transgender-as-a-sexual-health-condition-a9d9cf405707.

Fairclough, Norman. 2001. *Analysing Discourse: Textual analysis for social research*. London: Routledge.

Fairclough, Norman. 2013. *Language and Power*. London: Routledge.

Feldman, Jamie, George R. Brown, Madeline B. Deutsch, Wylie Hembree, Walter Meyer, Heino FL Meyer-Bahlburg, Vin Tangpricha, Guy T’Sjoen, and Joshua D. Safer. 2016. “Priorities for Transgender Medical and Health Care Research.” *Current Opinion in Endocrinology, Diabetes, and Obesity* 23 (2): 180-87.

Feldman, M. S., Kaj Skoldberg, Ruth Nicole Brown, and Debra Horner. 2004. "Making Sense of Stories: A Rhetorical Approach to Narrative Analysis." *Journal of Public Administration Research and Theory* 14 (2): 147–70.

Ferguson, Joshua M. 2016. "Non-Binary Trans Subject: Exiting the Attachment to the Transgender Metanarrative of Man/Woman." PhD diss., University of British Columbia. https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0314123.

Foucault, Michel. 1973. *Madness and Civilization: A History of Insanity in the Age of Reason*. Translated by Richard Howard. New York: Vintage Books.

———. 1978. *The History of Sexuality*. 1st American ed. New York: Pantheon Books.

———. 2011. *Madness: The Invention of an Idea*. Translated by Alan Sheridan. New York: Harper Perennial.

———. 2013. *Herculine Barbin*. Knopf Doubleday Publishing Group.

Frances, Allen J., and John Nardo. 2013. "ICD-11 Should Not Repeat the Mistakes Made by DSM-5." *British Journal of Psychiatry* 203 (1): 1-2.

Fraser, Lin, Dan H. Karasic, Walter J. Meyer III, and Kevan Wylie. 2010. "Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults." *International Journal of Transgenderism* 12 (2): 80–85.

Gehi, Pooja S., and Gabriel Arkles. 2007. "Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People." *Sexuality Research & Social Policy* 4 (4): 7–35.

Giovannetti, Justin. 2018. "Wynne Pledges $2.1-Billion in Funding for Mental Health in Ontario Ahead of Election," March 21, 2018. https://www.theglobeandmail.com/canada/article-wynne-pledges-21-billion-in-funding-for-mental-health-in-ontario/.

Goldberg, David P., and Peter Huxley. 1992. *Common Mental Disorders: A Bio-Social Model*. Common Mental Disorders: A Bio-Social Model. New York, NY, US: Tavistock/Routledge.

Goodley, Dan. 2014. *Dis/Ability Studies: Theorising Disablism and Ableism*. London: Routledge.

Graham, Hilary. 2004. "Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings." *The Milbank Quarterly* 82 (1): 101–24.

Hartford, Kathleen, Ted Schrecker, Mary Wiktorowicz, Jeffrey S. Hoch, and Crystal Sharp. 2003. "Report: Four Decades of Mental Health Policy in Ontario, Canada." *Administration and Policy in Mental Health and Mental Health Services Research* 31 (1): 65–73.

Hendricks, Michael L., and Rylan J. Testa. 2012. "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model." *Professional Psychology: Research and Practice* 43 (5): 460-67.

Herzog, Katie. 2017. "The Detransitioners: They Were Transgender, Until They Weren't." Accessed April 16, 2018. https://www.thestranger.com/features/2017/06/28/25252342/the-detransitioners-they-were-transgender-until-they-werent

Howell, Alison. 2011. *Madness in International Relations: Psychology, Security, and the Global Governance of Mental Health*. London: Routledge.

Hughes, Bill. 2005. "What Can a Foucauldian Analysis Contribute to Disability Theory?" In *Foucault and the Government of Disability*, edited by Shelley Tremain, 78–92. Ann Arbor: University of Michigan Press.

Hughes, Tonda L., and Michele Eliason. 2002. “Substance Use and Abuse in Lesbian, Gay, Bisexual and Transgender Populations.” *Journal of Primary Prevention* 22 (3): 263–98.
International Classification of Disorders 11. 2018. “Gender Incongruence.” World Health Organization. http://id.who.int/icd/entity/411470068.
Isaac, Rael Jean, and Virginia C. Armat. 1990. *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill.* Free Press.
Jordan, Karen M. 2000. “Substance Abuse among Gay, Lesbian, Bisexual, Transgender, and Questioning Adolescents.” *School Psychology Review* 29 (2): 201-6.
Kafer, Alison. 2013. *Feminist, Queer, Crip*. Bloomington: Indiana University Press.
Kelleher, Cathy. 2009. “Minority Stress and Health: Implications for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Young People.” *Counselling Psychology Quarterly* 22 (4): 373–79.
Knott, Janet. 2018. “An MRI brain scan can reveal if you are transgender, says study.” *National Post*, May 21. https://nationalpost.com/news/world/an-mri-brain-scan-can-reveal-if-you-are-transgender-says-study.
Kutchins, Herb, and Stuart A. Kirk. 2003. *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: The Free Press.
Lafrance, Michelle N, and Suzanne McKenzie-Mohr. 2013. “The DSM and Its Lure of Legitimacy.” *Feminism & Psychology* 23 (1): 119–40.
Lasswell, Harold D. 1970. “The Emerging Conception of the Policy Sciences.” *Policy Sciences* 1 (1): 3–14.
Lawrence, Anne A. 2003. “Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery.” *Archives of Sexual Behavior* 32 (4): 299–315.
Lev, Arlene Istar. 2006. “Disordering Gender Identity: Gender Identity Disorder in the DSM-IV-TR.” *Journal of Psychology & Human Sexuality* 17 (3–4): 35–69.
Levine, Stephen B., and Anna Solomon. 2008. “Meanings and Political Implications of ‘Psychopathology’ in a Gender Identity Clinic: A Report of 10 Cases.” *Journal of Sex & Marital Therapy* 35 (1): 40–57.
Lewis, Bradley. 2006. *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry*. Ann Arbor: University of Michigan Press.
Marston, Greg, and Rob Watts. 2003. “Tampering with the Evidence: A Critical Appraisal of Evidence-Based Policy-Making.” *The Drawing Board: An Australian Review of Public Affairs* 3 (3): 143–163.
Mayes, Rick, and Allan V. Horwitz. 2005. “DSM-III and the Revolution in the Classification of Mental Illness.” *Journal of the History of the Behavioral Sciences* 41 (3): 249–267.
Meekosha, Helen, and Leanne Dowse. 2007. “Integrating Critical Disability Studies into Social Work Education and Practice: An Australian Perspective.” *Practice* 19 (3): 169–83.
Mental Health Commission of Canada. 2012. “Changing Directions, Changing Lives: The Mental Health Strategy for Canada.” Mental Health Commission of Canada.
———. 2018. “About Us.” 2018. https://www.mentalhealthcommission.ca/English/about.
Menzies, Robert, Brenda A. LeFrançois, and Geoffrey Reaume. 2013. “Introducing Mad Studies.” *Mad Matters: A Critical Reader in Canadian Mad Studies*.
Morrow, Marina. 2013. “Recovery: Progressive Paradigm or Neoliberal Smokescreen?” In *Mad Matters: A Critical Reader in Canadian Mad Studies*, edited by Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 323–33. Toronto: Canadian Scholars’ Press.

Moss, Pamela. 2016. “Perching as a Strategy for Seeking Legitimacy for Broken Embodiments: Embracing Biomedical Claims for ME.” In *Mobilizing Metaphor: Art, Culture, and Disability Activism in Canada*, edited by Christine Kelly and Michael Orsini, 221–40. Vancouver: UBC Press.

Movement for Global Mental Health. n.d. “Home.” Accessed June 30, 2018. http://www.globalmentalhealth.org/.

Mulé, Nick J. 2015. “The Politicized Queer, the Informed Social Worker: Dis/Re-Ordering the Social Order.” In *LGBTQ People and Social Work: Intersectional Perspectives*, edited by Brian O’Neill, Tracy A. Swan, and Nick J. Mulé, 17–36. Toronto: Canadian Scholars’ Press.

Nanda, Serena. 2014. *Gender Diversity: Crosscultural Variations*. 2nd ed. Long Grove: Waveland Press.

Nye, Robert A. 2003. “The Evolution of the Concept of Medicalization in the Late Twentieth Century.” *Journal of the History of the Behavioral Sciences* 39 (2): 115–29.

Okpaku, Samuel O., and Sanchita Biswas. 2014. “History of Global Mental Health.” In *Essentials of Global Mental Health*, edited by Samuel O. Okpaku, 1–10. Cambridge: Cambridge University Press.

Oliver, Mike. 2013. “The Social Model of Disability: Thirty Years On.” *Disability & Society* 28 (7): 1024–26.

Ontario Ministry of Finance. 2017. *2017 Ontario Budget: A Stronger, Healthier Ontario*. Toronto: Ministry of Finance. http://books.scholarsportal.info/viewdoc.html?id=/ebooks/ebooks3/ogdc/2017-10-10/3/339601-f.

Ontario Ministry of Health and Long-Term Care. 2011. “Open Minds, Healthy Minds: Ontario’s Comprehensive Mental Health and Addictions Strategy.” Queen’s Printer for Ontario.

———. 2016. “Sex Reassignment Surgery.” Ontario Ministry of Health and Long-Term Care. 2016. http://www.health.gov.on.ca/en/pro/programs/srs/.

Orsini, Michael, and Francesca Scala. 2006. “‘Every Virus Tells a Story’: Toward a Narrative-Centred Approach to Health Policy.” *Policy and Society* 25 (2): 109–30.

Orsini, Michael, and Miriam Smith. 2010. “Social Movements, Knowledge and Public Policy: The Case of Autism Activism in Canada and the US.” *Critical Policy Studies* 4 (1): 38–57.

Owen, Gabrielle. 2014. “Adolescence.” *TSQ: Transgender Studies Quarterly* 1 (1–2): 22–24.

Park, John Everett. 1970. *Textbook of Preventive and Social Medicine: A Treatise on Community Health.* Jabalpur: Banarsidas Bhanot.

Park, Melissa M., Hiba Zafran, Janet Stewart, Jon Salsberg, Carolyn Ells, Suzanne Rouleau, Orly Estein, and Thomas W. Valente. 2014. “Transforming Mental Health Services: A Participatory Mixed Methods Study to Promote and Evaluate the Implementation of Recovery-Oriented Services.” *Implementation Science* 9 (September): 119-130.

Parsons, Wayne. 2002. “From Muddling through to Muddling Up-Evidence Based Policy Making and the Modernisation of British Government.” *Public Policy and Administration* 17 (3): 43–60.

Patel, Vikram, Alan J Flisher, Sarah Hetrick, and Patrick McGorry. 2007. “Mental Health of Young People: A Global Public-Health Challenge” *Lancet* 369: 1302-13.

Pilling, Merrick Daniel. 2014. “Queer and Trans Madness: Biomedical and Social Perspectives on Mental Distress.” PhD diss., York University.

https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/29933/Pilling_Merrick_D_2014_PhD.pdf?sequence=2&isAllowed=y.
Price, Margaret. 2015. “The Bodymind Problem and the Possibilities of Pain.” *Hypatia* 30 (1): 268-284.
Public Health Agency of Canada. 2016. “Social Determinants of Health.” Canadian Best Practices Portal - CBPP. June 27, 2016. http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/.
Rosen, George. 1974. *From Medical Police to Social Medicine: Essays on the History of Health Care.* New York: Neale Watson Academic Publications.
Sanderson, Ian. 2002. “Evaluation, Policy Learning and Evidence-based Policy Making.” *Public Administration* 80 (1): 1–22.
Schizophrenia Society of Ontario. 2013. “It Doesn’t Work: Unpacking Mental Health Policy and Legislation.” http://www.schizophrenia.on.ca/getmedia/e90d8303-6799-441f-ba11-3b76423997b0/It-Doesn-t-Work-one-page-up,-no-bleed.pdf.aspx.
Schultz, Susanne. 2006. “Dissolved Boundaries and ‘Affective Labor’: On the Disappearance of Reproductive Labor and Feminist Critique in Empire.” *Capitalism Nature Socialism* 17 (1): 77–82.
Schulz, Sarah L. 2018. “The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria.” *Journal of Humanistic Psychology* 58 (1): 72–92.
Serano, Julia. 2009. “Psychology, Sexualization and Trans-Invalidations.” http://www.juliaserano.com/av/Serano-TransInvalidations.pdf.
———. 2014. “What Is Subversivism?.” http://juliaserano.blogspot.com/2014/02/what-is-subversivism.html.
Shimrat, Irit. 2013a. “The Tragic Farce of ‘Community Mental Health Care.’” In *Mad Matters: A Critical Reader in Canadian Mad Studies*, edited by Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 144–57. Toronto: Canadian Scholar’s Press Inc.
———. 2013b. “The Tragic Farce of ‘Community Mental Health Care.’” In *Mad Matters: A Critical Reader in Canadian Mad Studies*, edited by Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, 144–57. Toronto: Canadian Scholar’s Press Inc.
Shoemaker, Pamela J., and Tim P. Vos. 2009. *Gatekeeping Theory.* London. Routledge.
Spade, Dean. 2003. “Resisting Medicine, Re/Modeling Gender.” *Berkeley Women’s Law Journal* 18: 15-37.
Spitzer, Robert L. 1981. “The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues.” *American Journal of Psychiatry* 138 (2): 210–215.
Stieg, Cory. 2017. “Confused About Gender Dysphoria? Here's What It Is — & Isn't.” *Refinery 29*, April 26. https://www.refinery29.com/2017/04/151585/gender-dysphoria-identity-disorder-meaning.
Stryker, Susan. 2014. “Biopolitics.” *TSQ: Transgender Studies Quarterly* 1 (1–2): 38–42.
Summerfield, Derek. 2012. “Afterword: Against ‘Global Mental Health.’” *Transcultural Psychiatry* 49 (3–4): 519–30.
———. 2013. “‘Global Mental Health’ Is an Oxymoron and Medical Imperialism.” *British Medical Journal* 346.
Szasz, Thomas. 1974. *The Myth of Mental Illness*. Harper & Row New York.
Szasz, Thomas Stephen. 1997. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. Syracuse University Press.

Telesur. 2018. "'Finally': World Health Organisation Announces It Will No Longer Classify Being Transgender a Mental Disorder." June 19, 2018. https://www.telesurtv.net/english/news/Finally-World-Health-Organisation-Announces-It-Will-No-Longer-Classify-Being-Transgender-a-Mental-Disorder-20180619-0008.html.

Terzi, Lorella. 2004. "The Social Model of Disability: A Philosophical Critique." *Journal of Applied Psychology* 21 (2): 141–57.

Thomas, Carol. 2013. "Disability and Impairment." In *Disabling Barriers - Enabling Environments*, edited by John Swain, Sally French, Colin Barnes, and Carol Thomas, 3rd ed., 9–18. Los Angeles: SAGE.

Truitt, Jos. 2011. "I Am Not Your Tragic Trans Narrative." *Feministing* (blog). 2011. http://feministing.com/2011/05/31/i-am-not-your-tragic-trans-narrative/.

Ussher, Jane M. 2013. "Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology." *Feminism & Psychology* 23 (1): 63–69.

Ustün, T. B. 1999. "The Global Burden of Mental Disorders." *American Journal of Public Health* 89 (9): 1315–18.

Vagianos, Alanna. 2018. "Being Transgender Is No Longer Considered A Mental Disorder By World Health Organization." HuffPost UK. June 19, 2018. http://www.huffingtonpost.com/entry/being-transgender-no-longer-considered-a-mental-disorder-by-world-health-organization_us_5b295ddae4b0f0b9e9a630b2.

van Dijk, Teun A. 1993. "Principles of critical discourse analysis." *Discourse & Society* 4 (2): 249-283.

van Hulst, Merlijn, and Dvora Yanow. 2016. "From Policy 'Frames' to 'Framing' Theorizing a More Dynamic, Political Approach." *The American Review of Public Administration* 46 (1): 92–112.

Vidal, Fernando. 2009. "Brainhood, Anthropological Figure of Modernity." *History of the Human Sciences* 22 (1): 5–36.

Wadman, Meredith. 2018. "New paper ignites storm over whether teens experience 'rapid onset' of transgender identity." *Science Mag*, August 30. http://www.sciencemag.org/news/2018/08/new-paper-ignites-storm-over-whether-teens-experience-rapid-onset-transgender-identity.

Weiss, Gilbert, and Ruth Wodak, eds. 2003. *Critical Discourse Analysis: Theory and Interdisciplinarity*. Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan.

West, Candace, and Don H. Zimmerman. 1987. "Doing Gender." *Gender & Society* 1 (2): 125–51.

White, Ross. 2013. "The Globalisation of Mental Illness." *Psychologist* 26 (3): 182–85.

Wierckx, Katrien, Eva Van Caenegem, Els Elaut, David Dedecker, Fleur Van de Peer, Kaatje Toye, Steven Weyers, et al. 2011. "Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men." *The Journal of Sexual Medicine* 8 (12): 3379–88.

Wiktowicz, Mary E. 2008. "Restructuring Mental Health Policy in Ontario: Deconstructing the Evolving Welfare State." *Canadian Public Administration* 48 (3): 386–412.

Wilson, Mitchell. 1993. "DSM-III and the Transformation of American Psychiatry: A History." *American Journal of Psychiatry* 150: 399–410.

Withers, A. J. 2012. *Disability Politics & Theory*. Halifax: Fernwood Publishing.

———. 2013. “Disabling Trans: Political Implications and Possibilities of Constructions of Trans as Disability.” Toronto, Ontario: York University.
World Health Organization. 1992. *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Vol. 1. World Health Organization.
———. 2011. “International Statistical Classification of Diseases and Related Health Problems.” http://apps.who.int/classifications/icd10/browse/2016/en.
———. 2018a. “Mental Health.” http://www.who.int/mental_health/en/.
———. 2018b. “WHO | What We Do.” http://www.who.int/about/what-we-do/en/.
———. 2018c. “ICD-11 - Mortality and Morbidity Statistics.” https://icd.who.int/browse11/l-m/en.
World Professional Association for Transgender Health. 2018a. “Missions and Values.” http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1347&pk_association_webpage=3910.
———. 2018b. “Standards of Care, Version 7.” http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926.
———. 2018c. “The Standards of Care.” http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351.
Young, Leslie. 2018. “MRI scans suggest transgender people’s brains resemble their identified gender: study.” *Global News*, May 24. https://globalnews.ca/news/4223342/transgender-brain-scan-research/.