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Éditorial/Editorial

I am a clinical and research psychologist who belonged to the American Psychological Association until I resigned some years back because of their allowing psychologists to participate in torture and because of their frantic, well-funded push to get states to allow psychologists to prescribe psychiatric drugs. While still a member, I stood outside the annual convention one year and realized I was loathe to enter. Many psychologists and other therapists are humane, respectful, caring, and careful to avoid dogma and dangers to those they try to help. But in her new book, *Psychiatry and the Business of Madness*, Bonnie Burstow describes with scrupulous care the ways that various systems make such therapists all too rare, and she lets those who have been harmed speak up in heartbreaking detail. As a result, for instance, instead of having us simply read that Irit Shimrat tore off her clothes and ran down the hall of her apartment building banging on doors to warn people of the dangers of war and allowing us to think, "She was clearly nuts!" Burstow gives us Shimrat's own words and then points out, in effect, how strange it is that so few of us are in close enough touch with the horrors of war that we bang on doors in warning. We would do well to consider this.

Many of the pioneering critics of the traditional mental health system have focused on psychiatrists, the American Psychiatric Association, and that association's *Diagnostic and Statistical Manual of Mental Disorders*. But depressingly often, I have also seen psychologists, social workers, and nurses sometimes reduce suffering but often dehumanize sufferers, drug them, shock them, and inflict various kinds of physical and psychological violence on them. I have also heard marriage and family therapists, counselors, and even clergy -- for heaven's sake, clergy! who are supposed to know oppression and spiritual or existential crisis when they see them! -- leaping to assign or perpetuate psychiatric labels, misinterpret behavior in the most bizarre of ways, and push both isolation and drugs even when they are harmful. Something is very wrong when a minister describes grief over the loss of a loved one as a Major Depressive Episode, as the DSM-IV authors did (on the fourth page of the listing of that category).

Numerous powerful forces help perpetuate the harm, including media people, who played major roles in a recent, mysterious failure to report a shocking instance of corruption. Columbia University medical ethics expert Dr. David Rothman wrote an expert witness report scrupulously documenting this: In 1995, the very year after DSM-IV appeared, three powerful psychiatrists

were paid nearly $1 million by Janssen Pharmaceuticals to write a "Practice Guideline" for treating Schizophrenia, and the guideline -- as promised -- had the conclusion that Janssen's new drug Risperdal was the best option. The lead psychiatrist of the three was Allen Frances, who had the previous year published DSM-IV, the psychiatric "Bible" of diagnoses, and thus was enormously influential and assumed to be credible. As Dr. Rothman noted, the guideline was in utter disregard of what the research showed. Besides the guideline, what the three men did for their pay was to create a detailed program for marketing Risperdal by -- among other things -- bringing hired-gun psychiatrists to give "Continuing Education" courses to promote the drug. Risperdal is one of the most dangerous of all psychiatric drugs. Most people are unaware of this corruption, which I call "Diagnosisgate." This is because although there were five major media stories about the Rothman Report, in not one were the three psychiatrists, their "practice guideline," or their nearly million-dollar pay mentioned. In my article called "Diagnosisgate," which appeared earlier this year in APORIA, I said it was an unexplained mystery why this was so, but despite this calling of attention to the media's blackout, that blackout has continued.

Another major player in concealing harm is the legislator, because it is so easy to propose laws and earmark funding that perpetuate the traditional approaches, playing into the common fear that deviating from the "standard of care" -- primarily psychotherapy and drugs -- must be dangerous. And in our chapter in Bias in Psychiatric Diagnosis, Jeffrey Poland and I wrote about a number of interlocking systems that perpetuate harm in the mental health system, with our focus on psychiatric diagnosis, which is the most fundamental cause of harm in the mental health system. We included as the perpetuating entities both governmental and private insurance companies, Pharma, contemporary people's desperate need in their overly busy lives to find silver bullet answers to their problems, and a deep-seated and unquestioning belief in science/medicine/technology.

Every problem in the system begins with psychiatric diagnosis. After all, until they have labeled you mentally ill, they are not supposed to treat you, and once you are labeled, there is little they cannot do to you. As I learned from my two years on two DSM-IV committees, psychiatric diagnoses are unscientific, do not lead to reduction of suffering (certainly not in ways that are not better done without pathologizing), and carry enormous risks of harm, including deprivation of every conceivable human right. "Patients" are socialized to feel grateful that their alleged mental illness has been named, and they are virtually never informed that getting a label can destroy their lives, so there is no informed consent. Nine people filed complaints about harm from psychiatric diagnosis with the American Psychiatric Association's ethics committee, and these were dismissed with no attention to their merits. The Civil Rights Office of the US Department

of Health and Human Services did the same with complaints that we filed. We have therefore demonstrated that not only is psychiatric diagnosis totally unregulated, but also that the one private entity and one government entity that by all rights ought to regulate it, redress harm, and prevent future harm refuses to take a single step to do so.

Many years ago I proposed holding Congressional Hearings (https://www.change.org/p/everyone-who-cares-about-the-harm-done-by-psychiatric-diagnosis-endorse-the-call-for-congressional-hearings-about-psychiatric-diagnosis) about psychiatric diagnosis as a major step toward exposing its harms and creating a national conversation about what's to be done. Burstow describes hearings about harm in the system and hearings about electroshock that were held in Canada. One thing we can all immediately do is to follow this lead and demand such public hearings in our own countries and on global scales.

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Abstract
In 2010, Ontario's Ministry of Education introduced a revised Health and Physical Education (H&PE) curriculum that promised to be a vital health promotion initiative. Yet, after a minority conservative backlash, the Ontario government withdrew the sexual health sections from the elementary school curriculum, reverting it back to its 1998 content. This study is a content analysis, informed by queer theory and institutional ethnography, of the current and proposed H&PE documents, with a focus on the sex education component. This research aims to examine i) the specific differences between the new and old H&PE documents with respect to referencing and delivering sex education, and more specifically sex education on queer/trans* issues; and ii) the potential social exclusion that the absence of queer/trans* curriculum content imposes on youth. The findings demonstrate that evidence-informed policy development cannot always overcome political power imbalances, such as those created by the socially constructed ideology of heteronormativity. As the Ontario government prepares to implement the reformed curriculum, this study provides insight into its controversial history and the complexities of policy development—insights that may extend beyond this moment.

Key Words Ontario, queer theory, sex-education, sexual health, social determinants of health, youth

Is Queer Sex Education in Ontario Finally Out of the Closet?

CAMERON MCKENZIE

Introduction

In light of the current controversy surrounding the newly implemented sex education curriculum for grades K-8 in Ontario, this timely comparison between the new and old curriculums is all the more critical. To this aim, this study provides such engagement, comparing the out-dated and new (proposed) sex education curricula to show how queer and trans* [i] and sexual pleasure issues are currently absent. I argue that withdrawing references to sexuality and gender construction exemplifies Foucault's contention that discourse regulates and perpetuates "power-knowledge", thereby reproducing historical power relations of sexual morality.[1] Queer theory, informed by Foucault and materialized within Dorothy Smith's method of textual analysis through institutional ethnography, illuminates the power relations within the microenvironment of the public school system and the micro-environment of society.[2]

Social exclusion, a vital social determinant of health, provides the rationale for this undertaking.[3,4] I argue that the sex education curriculum in Ontario excludes queer and trans* youth, through omission of gender identity and queer issues, and through overemphasising heteronormativity. Those who do not fit the normative mold become visibly 'othered'.[5,1] This content analysis demonstrates that the heteronormative culture of policy-making contradicts the rhetorical commitment to "evidence-based" practices.[6] The 5-year struggle to update the sex education curriculum in Ontario demonstrates the importance of apprehending underlying power dynamics that prevent social change.

Background

With Ontario poised to update its sexual education

curriculum in autumn 2015, its controversial history provides a "teachable moment" for understanding the policy development process. The current elementary curriculum was last updated in 1998 despite an updated curriculum proposed in January 2010.[7,8] This proposed curriculum emerged from extensive consultation with Ontario public and Catholic school board representatives, and more than 50 writers from the education and public health sectors. [8] Reviewed by over 150 individuals and teams and pilot-tested through school boards, sports associations, and health units, it was considered "the most significant health promotion intervention this province has ever seen" for its 2.1 million children and their families.[8 p7] Yet, due to a minority community opposition, the sex education components of the broader Health and Physical Education (HP&E) curriculum were held back for "rethinking".[9] In April 2010, Ontario reverted to its outdated 1998 content.[10] Consequently, it does not reflect how young people now find information (e.g., social media), excludes references to healthy, pleasurable sexuality and omits queer and trans* issues. As such, this curriculum does not comply with international equity and inclusion policies or with the Canadian Guidelines for Sexual Health.

Rayside attributed this stasis to media portrayals of sexuality, the ruling position of the educator and institution, the political legacy of homophobia, social conservatism and religious resistance, and media sensualisation of the issues.[11] Ongoing sex education curriculum debates illustrate the persistence of the legal purview over sexual behaviour when it becomes a "social concern" or the subject of "political uproar", particularly when morality involving "obscenity, money, minors, and [to this day] homosexuality" are contested.[12 p160] Opposition to a comprehensive sex education curriculum coalesced when "forms of sexuality", like homosexuality and childhood sexual development, were translated to textual discourse, for these counter heteronormative economic productivity.[1 p36]

In Ontario, the backlash came from conservative public discourse, which posits a romanticised childhood innocence corrupted by exposure to sexual themes and messages.[9] Privileged, conservative groups included right-wing fundamentalists or evangelical Christians, and "counterparts in Muslim, Sikh, Hindu, and Jewish religious constituencies".[11 p2] The debate played out in a heated competition between Tory conservatism and Liberal opportunism. Premier McGuinty's argued that children ought to have accurate information on sexuality before becoming sexually active, for making healthier choices[13 para 6], until he feared that the contentious curriculum was "losing ground" with voters.[9 para 16]

Interestingly, resistance arose from "Christian groups outside of publicly funded Catholic educators".[14 para 9] Evangelical pastor and President of Canada Christian College, Charles McVety, called the proposed curriculum a "form of corruption", for being "sexually explicit", arguing that "it is unconscionable to teach 8-year-old children about same-sex marriage, sexual orientation and gender identity".[15 para 2] According to Brian Rushfield, Executive Director of Canada Family Action, it was "bordering on criminal … [t]o cause confusion in a young child's mind about being male or female ….".[15 para 3] These sentiments reflect a mass "erotic hysteria" to protect children from inherently damaging notions of sexuality prevalent from the 19th century onward.[12 p141] Child masturbation was discouraged, while "erotic dissidence" —including homosexuality, trans-sexuality, and sadomasochism—were repressed.[12 p163] To this day, expressions of these sexualities may cause social discord and familial rejection.[16] This repression occurs due to sexuality's susceptibility to "pathological processes" requiring "therapeutic or normalizing interventions".[1 p68] Such rejection, however, also critically impacts young people's mental health and high-risk behaviours.[17] As Rubin explains, "recurring battles" emerge in the ideological battleground of sexuality, where church, state, family, psychologists, and the media define and produce "acceptable" content that most impacts the "groups whose experience they name, distort, and endanger".[12 p165] Implementing a more inclusive educational system confronts notions of normalcy while forcing engagement "with such conundrums".[18 p66]

Theoretical framework

A social-determinants-of-health (SDH) framework considers the broader structural barriers to good health, as opposed to individual, biomedical explanations for health outcomes.[19,4] This framework illuminates that resources for health extend beyond health care because "social exclusion is an expression of unequal relations of power among groups in society responsible for determining access to…resources".[3 p100] Thus, the potential "othering" of queer and trans* youth in the educational system is of serious concern. Indeed, the new curriculum was considered an effective health promotion tool precisely because it attempted to include issues of sexual orientation and gender identity.[7] In excluding this content, educational institutions become complicit in perpetuating fear, hostility, and marginalization

of these aspects of young people's identities. A growing body of literature highlights how gender-nonconforming adolescents experience health inequities.[20,21] Suicide and suicide ideation are especially serious concerns.[22,23]

Queer theory adds analytical tools for a more nuanced analysis of social exclusion in a heteronormative society than can be attained solely through an SDH framework. Queer theory recognizes sexuality and desire as "much more than mere, even minor, features of social life".[24 pviii] Rather, they are "constitutive elements" of identity as vital as race, gender, and class, and underlie a heterosexism that directs violence and hatred at those who exist outside the norm.[24 pviii] Foucault's "History of Sexuality" characterises sex in the eighteenth and nineteenth centuries as an intentional, political tool of power to uphold the pedagogy and economics of heteronormative reproduction, with homosexuality, in particular, subject to medicalization, legal frameworks, and other power apparatuses, like the public education system.[1] Thus, heteronormativity assumes a moral position on sexuality.[25] Morris defines heteronormativity as "the illusion that heterosexuals are the only people on the planet and are the center of all sexual practices".[26 p9] Within this space, queer theory emerged, denying dualisms of gay/straight and male/female and taking up a more inclusive conceptualization.[27] Indeed, the use of the term "queer" attempts to reclaim a previously derogatory term, while embracing all men and women, including trans* individuals who fall outside heteronormativity.[28,29] "Queer" is also a term that is favoured by the younger generation.[28] "Queerness" seeks to "offer more individual spaces for the construction of identity" that are decentered from otherwise arbitrary features, such as lifestyle choices.[28 p154] The term "queer" emerges from the theoretical assertion that sexual and gender identities are socially constructed, stemming directly from Foucauldian discourses in which homosexuality evolved as a stable and identifiable category as a means to pit it against the ideal of heterosexual monogamy.[1,27] Within queer communities, "the hegemonic constitution of masculinity" persists and alienates those who do not fit its performative criteria.[30 p175] The categorization of gender identities and sexual behaviours, complicated along axes of race, class, age, (dis)ability, and so on, has aided the persistence of a hierarchy of sexual acceptability.[12] In this hierarchy, "sex is a vector of oppression" and stratification, along which a white, male "pervert" will be less affected than a "poor, black, female pervert",[12 p164] again demonstrating the interplay of SDH.

While queer theory was not the first to assert these ideas, it adds a proactive examination of how gender boundaries are regulated and contested.[31] Thus, queer theory demands recognition of sexual diversity and sexual power relations, and offers a more nuanced analysis of social exclusion in a heteronormative society, extending beyond hierarchical resource distribution. Queer theory alone can, however, sometimes "mute" group features of complex multiple subjectivities such as race, class and age, hence the advantage of combining it with SDH.[28 p156] When examining a curriculum implicating young people of multiple ethnicities, gender identities, and class divisions, an agreed-upon, inclusive form of sex education becomes all the more essential. As posited by Epstein, these multiple identities can be called upon in "productive tension" to strategically resist reification, drawing attention to the socioeconomic power dynamics at play.[28 p156]

Methods

My methodology rests upon the idea that sexual power relations are reflected and reinforced by public discourse, including public policy documents, curricula and the discussion and debates therein. These debates were largely formulated by the media, which portrayed a skewed right-wing, moralist position of the sexual education curriculum as harmful to elementary-aged children due to exposure to overly explicit, even "criminal" sexual content.[32,33 para 6] The full details of the curriculum, largely concealed from public view, became further obscured by smaller religious groups that introduced it to parents as "a sinister attempt to indoctrinate small children with tales of sexual adventure".[13 para 7] This media coverage exemplifies Foucault's seminal work on the role of discourse in shaping thinking and consciousness.[1]

Informed by Foucault, Dorothy Smith developed Institutional Ethnography (IE) as both a theory and a method for analyzing this discourse.[2,34-38] IE is in essence a mixed methodological approach, incorporating textual and data analysis with phenomenological and narrative data, making it an ideal method for examining the real world impact of a curriculum.[39] IE functions by problematizing everyday experience, emphasizing the importance of the researcher's "standpoint" over positivist objectivity, and seeking to uncover implicit "ruling relations" in social discourses.[36,2] It functions well alongside queer theory, which examines how texts historically create meanings around sexuality, by deconstructing these "meanings and contents, along with the power and concurrent identification of and with them".[40-42] In short, by comparing the old and new sex education

curricula, I provide a textual IE analysis that uncovers assumptions about those who are included or excluded, with or without power, consulted or disregarded, and whose voices are valued or dismissed, while queer theory reminds us that it is difficult to name those whose sexual desires are "conflictual, contradictory, inconsistent," and have a "fictive border".[43 p345, 42 p459]

Smith's ruling relations are the "total complex of activities differentiated into many spheres, by which our kind of society is ruled, managed, administrated".[2 p8] Emphasizing Smith's standpoint theory, this study seeks to expose the content and process from the point of view of an excluded group through a textual analysis that is enriched via informant interviews, fulfilling the multilayered IE approach. IE does rely upon interview transcripts, observation, and secondary research, but it treats these data sources as "entry points" into "webs of sociality and work", rather than as data sets for analysis.[44 p163] An entry point is located in the "everyday world" in which the particular text functions and is formed, at the local (educational institution) and extra local (community) level.[38 p191] This perspective also enhances queer theory, which has sometimes been critiqued for failing to situate texts within their geographic and social spaces.[27]

Four key informants brought perspectives based on their experiences with sex education issues generally and the Ontario curriculum specifically. Sarah Flicker (York University) has written extensively on adolescent sexual and reproductive health and consulted on the curriculum revisions. Rui Pires, Gay Men's Community Education Coordinator with the AIDS Committee of Toronto has been a sexual health advocate for over twenty years and oversees a peer support program for young gay and trans* men, inspired, in part, by the inadequacy of the sex education curriculum. Nick Mulé (York University) chairs the advocacy group Queer Ontario. He researches social exclusion/inclusion of gendered and sexually diverse populations and social policy affecting them. j Wallace is a queer/trans* parent who works in gender-based violence prevention, and sits on the Toronto District School Board. (He spoke outside of his role on the school board.) Interviews, lasting 30 to 45 minutes, were digitally recorded and transcribed. Key informants consented to use their full names. This group was not meant to be representative of expert opinion, but rather functioned as member checking to enhance interpretation.

Since IE does not treat the interview subject or "knower" from a position of bias, but rather as an "entryway into investigating the practices"—in this case, within the educational institution as both a place of learning and of social construction—the input of key informants with a personal interest in this topic and/or who identify as queer was a key aspect of the research. However, future research would benefit from including a wider array of participants. IE aligns with the perspective of queer theory, in which texts are seen to enforce "binary divides", and makes transparent the power that is "embodied in different levels of society".[27 p134] Taking the analysis one step further, queer theory also provides a platform to deconstruct, decenter and revise the "assimilationist politics" enforced by such texts.[27] Heteronormative politics in the modern West continue to support hierarchies of "sexual value" in which "reproductive heterosexuals" are highest, followed by coupled heterosexuals, trailed by other heterosexuals, and so on.[12 p149] In this hierarchy, masturbation or "solitary sex" has always been seen ambiguously, and definitely inappropriate for discussion in the presence of children.[1,12]

Content analysis

In each document, I determined the frequency of key terms deemed "controversial" in the sex education literature and policy debates,[45,15] specifically "gender identity" and "pleasure". In objecting to the new curriculum, the Campaign Life Coalition specifically argued the discussion of gender identity would "normalize homosexual family structures", offending some religious beliefs and creating significant confusion for young children.[46 para 9] These sentiments reflect what Monk describes as a "normative" idea that children are non-sexual.[47] The law to date vehemently protects childhood "innocence" from images of "adult sexuality", including portrayals of caring, responsible sexual relations.[12 p161] Ironically, young people may view

Table 1: Frequency of health-related terms

Health-related terms	Health and physical education curriculum	
	Current (n)	Proposed (n)
HIV	5	23
STDs/STIs	2	26
Bullying	41	39

graphic depictions of violence, but underage exposure to genitalia or healthy sexuality is criminalized, suggesting the urgent need for a sensitive, age-appropriate sex education curriculum, with references to sexual pleasure.[12]

While discussion of sexual pleasure is not innate to queer and trans* issues, its absence denotes a larger, societal discomfort with sexuality. Discussions of pleasure suggest non-reproductive, nonessential sexual characteristics that require strict regulation.[1] I thus also chose terms that explicitly refer to sexuality: "homophobia/homophobic" and "stereotypes/assumptions" along with "pleasure" and "gender identity" as "attitude-related terms" (Table 1).

I delineated the terms "HIV", "sexually transmitted diseases/infections (STD/STI)" and "bullying" as "health-related terms". It is noteworthy that the term "sexually transmitted disease" is considered out-dated. "Sexually transmitted infection" is "more encompassing, including infections that may be asymptomatic" and conveys less stigma than the term "disease".[48,49] "Bullying" was included because of its well-documented health effects, such as psychosocial stress and suicide.[22,23,50] Although bullying is not exclusive to queer students, they are internationally recognized as a vulnerable group.[51 p16] The United Nations Educational, Scientific and Cultural Organization notes international studies show that schools are one of "the most homophobic social spaces".[51 p16] One large international Canadian survey found that "three quarters of LGBTQ students and 95% of transgender students feel unsafe at school, compared to one fifth of straight students".[52 p5] Over half of LGBTQ students report verbal harassment regarding their sexual orientation, with 90% of transgender students having experienced such harassment. [52] Another school-based study indicated that a "combination of LGBT identity and school victimization predicted high levels of health risk behaviour during adolescence"[23 p224] and poor health outcomes, "including substance abuse, depression, anxiety and suicide attempts and completions".[22 p1611] The effects were worst for boys, who may feel pressured to conform to heteronormative, macho standards, while being simultaneously "othered" and harassed by peers and teachers for queer gender performance.[53 p113] Though such problems may not be solved by a sex education curriculum that addresses queer/trans issues, this same survey indicated that schools with policies and procedures "that explicitly address homophobia and have informed students of their existence" have marked improvements in student safety.[53 p7] A carefully constructed curriculum could contribute to these improvements in a respectful manner that builds acceptance for traditionally "othered" students and does not make "queer" a category of heterosexual deficit.[53]

The incidence of HIV and STIs is also higher in the queer community. In Canada, HIV affects about 0.2% of the general population and 15% of men who have sex with men, who accounted for 47% of all new and existing HIV cases in 2011.[54,55] The Canadian Guidelines on Sexually Transmitted Infection notes that sexually active youth under 25 face higher risk for STIs.[56] As well, Canadian data have identified men who have sex with men as the "primary community" affected by syphilis.[48,56] Although the impact of school-based sex education on health behaviours is unclear, the queer and trans* community is undoubtedly at high risk and should be a health promotion concern.

Finally, a juxtaposition of terms and the broader context of terms is discussed, because the frequency of terms is not as informative as the context within which they appear.

Results and analysis

Health-related terms

Analysis revealed a stark contrast between the presence and placement of controversial terms, and terms relating to gender identity. Within IE, "texts" are seen as having influence only insofar as they are "activated" or interpreted by the reader.[37,44 p167] The proposed curriculum includes discussion prompts to broach difficult subjects to facilitate discourse between teacher and student. Thus, the discrepancy between the frequencies of terms in both documents primarily stems from the absence or presence

Table 2: Frequency of attitude-related terms

Attitude-related terms	Health and physical education curriculum	
	Current (n)	Proposed (n)
Gender identity	7	19
Stereotype / assumption	7 / 2	21 / 13
Sexual pleasure / enjoyment	0	3 / 2
Homophobic / homophobia	3	2
Hispanic Men/Latinos	5	1

of these prompts. Looking at the frequency of health-related terms such as "HIV, STDs/STIs, Bullying" (Table 2), the proposed document shows greater attention to STIs, including the use of the updated terminology. The term STIs appears 26 times and HIV appears 23 times in the 2010 proposed curriculum, compared with only two and five times, respectively, in the current document. References to HIV and STIs appear throughout the grade seven and eight Human Development and Sexual Health section's student/teacher prompts. For example, in grade seven when discussing the benefits of abstinence at a young age, students are also taught some specific symptoms of STIs, such as, "redness or pain when urinating".[57 p184] They are also taught how STIs can be contracted: "sexual activities like oral sex, vaginal intercourse, and anal intercourse".[57 p184] They are also given detail about HIV, how it affects the body, and that it is "incurable".[57] HIV is briefly mentioned in the current curriculum, and defined only in the glossary. As Pires [October 31, 2013, oral communication] pointed out, a 2003 Canadian Youth, Sexual Health and HIV/AIDS Study revealed that "50% of grade nine students did not know there is no cure for HIV".[58] This is startling considering that, as of 2010, about one third of teens aged 15–17 have had sexual intercourse. These statistics alone evidence a lack of HIV information in schools.[59]

All interviewees stressed that bullying and stereotyping require more emphasis, even in the proposed curriculum. Pires notes: "I think we need to listen carefully to what kids are saying, and probably the most important thing to them is not the condom. The most important thing to them is the loneliness and bullying" [October 30, 2013, oral communication]. Thus, Pires links the underlying messages of the policy and its ultimate impact on students in light of the well-documented negative impact of bullying.[60,61] Although the term "bullying" appears almost the same number of times in both curricula, the proposed curriculum directly tackles specific causes or examples of bullying and stereotyping. The frequency tally of terms suggests that the proposed document gives more attention to attitudes and assumptions than the current one. The term "stereotype" appeared three times more often in the proposed than the current one and the term "assumption" appeared nearly seven times more often in the proposed document. "Stereotype" first appears in a teacher prompt in grade five under "Personal Safety and Injury". Students are asked to explain how negative actions cause harm: "name calling, making homophobic or racist remarks, mocking appearance or ability, excluding, bullying, sexual harassment",[57 p147] where the appropriate response prompt is:

> When someone appears to be different from us, whether it is because of something visible like a physical disability or something invisible like having an illness such as schizophrenia or HIV/AIDS, we may view him or her in a stereotyped manner and make assumptions. Stereotypes can have a strong, negative impact on someone's self-concept and well-being.[57 p147-8]

Students are taught that putting people down negatively impacts both their self-concept and the other person's, and leads to social estrangement (of the bully).[57] Grade six students are taught to challenge negative assumptions regarding "normality" in appearance, (dis)ability, gender roles, and cultural stereotypes, and that assumptions, "can make people who do not fit into the expected norms feel confused or bad about themselves, damaging their self-concept, and they can cause people to discriminate against and exclude those who are seen as 'different'".[57 p165]

Attitude-related terms

"Gender identity" is only mentioned twice in the main text of the current curriculum and five times in the glossary. The proposed curriculum has no glossary, as information typically appears in teacher prompts and information boxes. In the proposed document, gender identity appears 19 times in student-teacher prompts. For example, grade five students are prompted to discuss what they can and cannot control, such as "personal characteristics such as my skin colour, hair colour, whether I am male or female, my gender identity, sexual orientation [etc.]".[57] They are encouraged to consider a response such as "I cannot control these things, but I can control what I do and how I act".[57 p146] For those who do not identify with their biologically assigned gender or as straight, and who may not be "out", discussing sexual orientation and gender identity at school is essential to creating safe spaces [Mulé, October 31, 2013, oral communication].

Both documents mention homophobia equally frequently, but as discussed below, the context of these mentions suggest greater emphasis in the proposed curriculum. The proposed document's discussion of stereotypes and underlying assumptions positions sexual orientation and gender identity as socially constructed.

Pires, Wallace and Flicker mentioned the lack of emphasis on healthy, pleasurable sexual relationships in both documents. There were no references to sexual pleasure/enjoyment in the current document, and only three and two respectively in the proposed one. Flicker and Wallace felt this was a

large oversight, especially when children and teens are often learning about sex through online pornography.[62] Additionally, as per Rubin, the mainstream media continue to perpetuate "marginal sexual worlds [as] bleak and dangerous" and unrealistic depictions of a queer lifestyle.[12,63] As Allen points out, "Sexual education that concentrates on reducing unplanned pregnancies and sexually transmittable infections implies 'sexuality' is accompanied by 'risk' and must be avoided".[64 p145] The current curriculum thus invokes "moral panic" surrounding childhood over-sexualization and the preservation of the heterosexual family unit.[12 p168] In excluding references to healthy sexuality, relationships, and pleasure while focusing on potentially negative aspects of sexuality, youth remain vulnerable to media influences that perpetuate unrealistic sexual expectations, an unhealthy body image, and misogyny. As Rubin notes, "moral panic" thus disenfranchises both the "target population",[12 p168] (i.e., young people whose gender identity or sexuality may develop outside the heterosexual norm), and everyone else in society who is impacted by exclusionary legalities and policies. In this sense, the text is a "mechanism for coordinating activity across many different sites", as what is learned or omitted in the classroom spills out and implicates an individual's interaction with other socially mediated texts, such as parental, church, and media discourses.[65 p32] This is extremely difficult to avoid, as the curriculum itself is a product of the systematically managed macro framework, within which the curriculum is an apparatus of social power, keeping more progressive revisions at bay.[66]

Absence of information of trans issues*

Terms related to trans* identities only appear once within the grade eight curriculum in the proposed document and not at all in the current document.

Terms in context

Sexual health equity requires that education for teachers have a "political intent to help them question, disrupt, and redefine heteronormativity".[50 p387] But, training in addressing gender and sexual identity is lacking from teacher education.[67] Furthermore, teachers may lack administrative support for broaching queer issues in the classroom, may fear parental retribution, or may subscribe to heteronormative perceptions and stereotypes.[50] As Wallace pointed out, the proposed 2010 curriculum gives specific teacher prompts that may help mediate the discussion of specific issues: "If you were unsure of the topic, or uncomfortable with the topic, they can at least agree to say, 'Here's what we need to say, and this is the specific language'" [Wallace, November 1, oral communication]. For example, a grade six teacher prompt is "Having erections, wet dreams, and vaginal lubrication are normal things that happen as a result of physical changes with puberty. Exploring your body by touching or masturbating is something that many people will do and find pleasurable. It is common and is not harmful and is one way of learning about your body".[57 p168]

Smith's ruling relations are thus revealed in the text of a curriculum via its capacity to structure knowledge, organizations, and decision-making from within formal institutions, independently of individual influences (in this case, instructors or teachers).[34,35] As Smith has posited, the presence or absence of language in a text is crucial as it shows how every word can be problematized, bypassing the key issue: the need for healthier, inclusive sex education for young people.[34] The current curriculum provides a glossary of terms with minimal integration into the text; the proposed document embeds definitions within the text in a much more comprehensive fashion. For example, there is no difference in the number of times parent appears (71 times in both documents), but the context it appears in is significantly different. While the current document privileges parental and teacher rights/comfort levels over the emotional and physical safety of children, the proposed curriculum emphasizes student autonomy, with an objective of achieving of "…an understanding of sexual health in its broadest context".[57 p33]

The current curriculum makes no reference to children needing specific knowledge in order to make healthy decisions, instead emphasizing the rights of parents and teacher comfort level in guiding decisions:

> *Parents and guardians are the primary educators of their children* [emphasis added]. As children grow and develop relationships with family members and others, they learn about appropriate behaviours and values, as well as about sexuality. They are influenced by parents, friends, relatives, religious leaders, teachers, and neighbours, as well as by television, radio, videos, movies, books, advertisements, music, and newspapers….[68 p33]

This passage gives power to the parent or guardian to determine which fragments of knowledge and ideologies to transmit to their children. However, IE tells us that parents themselves are in a constant state of "articulation"—both exercising and undergoing the imposition of power within the larger hegemony. This form of organizational and textual power is ubiquitous and its significance is often undermined or marginalized, as the organization itself may not rest upon

the incorporation of one particular text.[38] This ubiquity, combined with the effect of a text being a definitive source of information "about something else", as abstracted from the information itself, renders any systemic change incredibly difficult.[38 p168]

Wallace felt that introducing material on puberty in grade seven and eight "doesn't match what students are experiencing with puberty" because "at least half of them need this at earlier ages because the students are encountering it elsewhere" [November 1, oral communication]. Furthermore, he felt that teaching sex education and gender identity issues at younger ages would help prevent bullying or "sexual misconduct in grade five and grade six" [November 1, oral communication]. Because attending school is a fundamental aspect of the everyday world of young people, "…engagement with the academic text in school can surpass even media and parental influence".[38 p174] The sex education curriculum standardizes what is known and understood, and how experiences of gender identity and sexuality are evaluated.[38] Thus, the curriculum joins parents, teachers, and students in "the same set of categories, connections, subject object relations, etc., carried by the text".[38 p174]

Furthermore, the current document defines "gender identity" as "a person's sense of self, with respect to being male or female" and relegates these issues in a glossary that may or may not be incorporated into classroom learning. In contrast, the proposed curriculum discusses gender identity, sexual orientation and development with meaningful, real-life examples in the classroom material and develops the issue through techniques such as student/teacher dialogue prompts. By removing discussion, the existing text leaves no room for debate of the relevant issues, "suppressing divergent perspectives" in favour of an authorized heteronormative discourse.[38 p176]

Discussion

I have argued that queer theory illuminates the unstated reasons for the 2010 rejection and current contestation of an evidence-informed sex education curriculum in Ontario: fear of the "other", or non-heteronormative and gender non-conforming expectations. The two documents' substantially different approaches to sexual orientation and gender identity exemplifies queer theory's premise of sexuality as social construct. The absence of reference to gender identity in the current curriculum is an outcome of textual instrumentality in different socio-political dimensions, like education, to express and enforce power "through boundaries and binary divides".[69] All interviewees felt the rigid binary created between male and female distorts children's reality, leaving many feeling isolated and lonely in the absence of role models or even the mention of gender and sexual orientation.

An equally important oversight is discussion of trans* sexuality. Gender dysphoria issues have been noted at very young ages, leading to childhood psychological distress and self-harming behaviours.[70,71] Suicide rates are also extremely high among transgender youth. One Ontario study found that 47% of transgender youth report strong suicidal ideation, and one fifth (19%) had attempted suicide.[72] Conversely, when parents, teachers and administrators are well-informed on trans* issues, trans* students feel accepted and happy, and bullying issues are mitigated. For example, one 2013 article discusses an 11-year-old transgender student, Wren, who self-identified as a boy.[73] Teachers and parents supported his identity, and once Wren came out to classmates, "nothing changed in his classroom—he said no one has bullied him or called him names". [73 para. 9] Yet, even in the curriculum slated for 2015, transsexuality is rarely discussed and the term "queer" is not used. As Foucault would argue, giving "queerness" a specific name would allow this identification a position of legitimization and power.[1]

When the Ontario government sent the revised curriculum back into the closet for "rethinking", then-Premier McGuinty argued that "parents are obviously not comfortable with this proposal".[74] In fact, the proposed curriculum had undergone wide consultation and had the blessing of the Catholic educators and parents and others.[75] As Wallace pointed out, parents often feel discomfort discussing sex and puberty with their children. He has heard many people say, "My parents told me nothing" [November 1, oral communication]. For many parents, having sex education taught in school is the only way for important information to reach their children in an accurate, sensitive manner. Yet, they are themselves "subjects" to the inter-textual nature of institutional interrelations within which the curriculum exists.[38] Parents reproduce society's aversion to discussing sexuality, gender identity, and pleasure, while pushing the agenda of "neutral" sexual health, threatening to withdraw funding or their children from institutions seen to push inappropriate topics onto children.[76] This historical aversion enforces student compliance with the "operation at its basis in the profound insecurity of the instructor's judgment"—the educator's own ambivalence and uncertainty surrounding the appropriateness of a sex education curriculum.[38 p190]

Indeed, in Canada and globally, curricular reform is beginning

to meet young people's needs regarding sexual health, with other provinces encapsulating sexual diversity needs much better than Ontario.[7] As early as grade three, Saskatchewan students are told that families can be very diverse, including having same-sex parents.[7] The grade six curriculum in New Brunswick emphasizes sexual stereotyping and sexual identity.[7,77] In Manitoba, the grade seven curriculum explicitly discusses gender stereotypes and social influences on sexuality to promote self-acceptance and the acceptance of others.[7,78]

That other provinces have implemented up-to-date, inclusive sex education policies tells us it is possible. One area for further research is the experience of other provinces: which stakeholders were involved, how these stakeholders differed from or were similar to those in Ontario, and how they mediated tensions to help to bring sex education out of the closet.

Although this study cannot make a direct link between serious potential health effects of social exclusion for the queer community (such as suicide) and the sex education curriculum per se, it does suggest that the government is neglecting this group's social exclusion. Given the serious potential consequences of exclusion, we could expect even minimal gains from including the queer community in the curriculum to be welcome —unless we understand the power of heteronormativity. As Pires added, the impact of bullying and poor response from the school systems was most apparent with recent coverage of teen suicides, "when all of a sudden all of these kids started talking about how they were being bullied, and how they didn't want it in their lives and how it continued in their lives". In light of the social isolation and bullying that queer/trans* youth experience, it is difficult to comprehend the ideological opposition to age-appropriate, comprehensive sex education [October 30, oral communication].

Flicker finds it absurd that sexualizing or corrupting "innocent" children is considered more of a threat to their well-being than social exclusion and out-dated information about health risks…She points out the need to strategize and mobilize through a complicated web of actors [October 31, oral communication]. To achieve sound public policy on contentious issues, grassroots organizations must be aware of the political pressure brought to bear on evidence, because evidence-informed policy development with extensive consultation with key stakeholders, no matter how thorough and compelling, is not guaranteed to overcome ruling relations, in this case stemming from the dominant ideology of heteronormativity. The Liberals, now with a majority government elected in 2014, and under an openly lesbian premier, Kathleen Wynne, have completed "fresh consultations on the long-delayed [curriculum] reforms … to allow implementation" in 2015.[79 para 19] Despite concern that reforms would be a watered-down version of the proposed curriculum, the Liberals have essentially resurrected the 2010 curriculum, with updates to information on HIV and "sexting".[6,79] The latest update also expands information on disability and sexuality, absent in the 2010 version. Given persistent heteronormative ideology, as evidenced by the current eruption of protest, the question remains whether these political changes are enough to keep Ontario's sex education curriculum out of the closet.

Notes

i.Trans* is an umbrella term for individual diversities across the spectrum of gender boundaries. The term includes "those who identify as transgender, genderqueer, trans, transsexual, androgynous, agender, bigender, two spirit, and gender non-conforming. [80]

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Abstract
Ce texte propose une analyse qui conjugue le versant politique et le versant expérientiel de la maternité. L'important corpus de littérature savante et populaire entourant l'arrivée d'un enfant est au cœur des normes contemporaines qui définissent la « bonne » mère. Se référant aux neurosciences et à la psychologie développementale, notamment, des experts formulent un ensemble de prescriptions parentales en vue de garantir aux enfants un développement physique, sensoriel et cognitif optimal. Il en découle une construction exigeante de la maternité qui repose sur des connaissances spécifiques et de grandes capacités physiques, mentales et matérielles. Ces pratiques et ces discours normatifs s'inscrivent dans l'exercice de la gouvernementalité que soutiennent la logique du risque et la gouvernance néolibérale.

Mots clés « bonne » mère parentalité, gouvernementalité, maternité, normes parentales, périnatalité

GOUVERNEMENTALITÉ DE LA « BONNE » MÈRE CONTEMPORAINE : EXPÉRIENCE ET RÉAPPROPRIATION DANS LA CLASSE MOYENNE SUPÉRIEURE

MARGUERITE SOULIÈRE & DENISE MOREAU

> Lentement j'en vins à comprendre le paradoxe contenu dans « mon » expérience de la maternité, à savoir que, quelque différente qu'elle soit de nombre d'expériences d'autres femmes, elle n'était pas unique ; et que ce n'est qu'en renonçant à une illusion de singularité que je pouvais espérer vivre une vie de femme tant soit peu authentique.
>
> Adrienne Rich[1]

Introduction

Depuis le tournant du 21e siècle, bien que la participation des femmes à la vie sociale et politique et leurs acquis sur les plans de la reproduction, de la sexualité et de la maternité ne soient pas globalement remis en question, on assiste à une régulation de la maternité qui, de manière souterraine, rattrape les femmes et les force à se redéfinir en fonction de nouvelles normes. Un ensemble de rationalités et de technologies politiques[2] apparaissent dans le champ de la parentalité où elles imposent de nouveaux discours de vérité. Les questions de diversité sociale et culturelle, de contexte et de choix personnel en sont habilement soustraites. Les pratiques et les discours normatifs visent tous les parents ; et ils deviennent les étalons à partir desquels les manières de faire des parents sont évaluées par les parents eux-mêmes, les autres et les experts en fonction de leur « compétence » parentale et en creux, sont ciblés les familles « à risque » ou « dysfonctionnelles » et les parents « négligents ».

Le présent article porte sur la construction sociopolitique du

devenir parent aujourd'hui (la focale est mise sur les mères, parce que les analyses de la recherche qui le soutiennent démontrent que ce sont elles qui sont le plus exposées et sensibles aux nouvelles prescriptions parentales. Il est toutefois important de souligner la présence, la participation et l'engagement quotidiens réels des pères dans le projet parental, ce qui sera souligné, bien que trop brièvement en section 3 et fera l'objet d'un article ultérieur). Le présent article propose une réflexion qui conjugue le versant politique de l'institution de la maternité et le versant subjectif des expériences ordinaires, toujours marquantes, parfois tragiques et « puissantifiantes » (j'ai entendu ce néologisme lors d'une interview de Stéphanie Saint-Amant, sémiologue et experte en périnatalité à la radio http://stephaniestamant.com/) que vivent les femmes en portant un enfant, en lui donnant naissance et observant son éveil au monde. Il repose sur l'idée que le contexte socioculturel, politique et économique établit les conditions de l'expérience subjective possible, et que par ailleurs, les discours de pouvoir peuvent faire l'objet de négociation, de transgression, de reformulation et de multiples appropriations.[3] Son orientation est donnée par la question de départ : Comment les mères concilient-elles leur expérience de la maternité avec les normes de parentalité contemporaines?

La construction des normes parentales contemporaines

Une prolifique production académique, médiatique et « experte » sur la parentalité et la compétence parentale émerge et déferle sur les sociétés occidentales libérales. Depuis les années 1990, de nouveaux modèles de mères dévouées, construits dans le courant du maternage intensif (intensive mothering),[4,5] font figure de repères pour normer[6] la parentalité et penser et définir le « bon parent » (surtout la « bonne » mère). Dans son livre, Hays[4] définit trois postulats idéologiques du maternage intensif : les mères sont par essence de meilleurs parents, le maternage doit être centré sur les besoins de l'enfant, et celui-ci est vu comme un être sacré et charmant qui répond aux attentes de ses parents. Le maternage intensif implique aussi l'idée que le parent doit apporter une stimulation intellectuelle constante à son enfant et finalement, convaincre qu'être parent est un véritable défi qui requiert une vaste gamme d'habiletés et d'expertise.[7] C'est à l'intersection des savoirs d'experts en psychologie développementale et en neurosciences, des discours de gouvernance néolibérale (fondée sur l'obligation-responsabilité individuelle) et de la logique du risque (articulée autour de la menace et du contrôle) que s'impose le maternage intensif comme repère majeur dans le système de normes parentales contemporaines.

La psychologie développementale

La fin de la seconde Guerre mondiale ouvre une période de rupture et de transition historique. L'une de ses manifestations est l'arrivée en grand nombre d'enfants nés « au matin du monde ».[8] Sans doute du fait de l'espoir de changement dont ils étaient investis et de leur présence massive, ces enfants ont commencé à être considérés comme des êtres à part entière ayant des libertés et des droits, plutôt que comme des êtres inachevés, subalternes et soumis. Au courant des décennies qui ont suivi, cette reconfiguration de l'enfance et de ses caractéristiques s'est aussi faite grâce aux savoirs d'experts qui enseignaient aux parents et aux mères les étapes normales du développement de leur enfant et les besoins associés à chacune.[9-12]

On éduque alors les parents pour qu'ils répondent désormais aux nouvelles demandes des enfants non seulement sur le plan physique, mais aussi sur les plans émotif, psychologique et cognitif. Prendre soin d'un enfant nécessite dès lors un savoir et un investissement parental plus exigeant que le simple « élevage » qui avait été la norme jusque-là.

Les neurosciences

À partir des années 1990, les neuroscientifiques s'adressent aux parents par l'entremise d'une imposante littérature scientifique et populaire, de revues et de sites Internet. Les travaux sur le cerveau ciblent deux nouvelles sphères de responsabilités : l'environnement affectif qui comprend le niveau de stress ; et la stimulation adéquate de l'enfant.

Se soustraire à ces responsabilités est désormais vu comme lourd de conséquences. Ainsi, les travaux de M. Meaney portent sur les liens entre le stress, les soins maternels et la génétique. Leurs résultats suggèrent la persistance (le reste de la vie) et la portée transgénérationnelle des effets des carences par des modifications génétiques (l'épigénétique) qui affectent le transfert de l'information (sans altérer l'ADN).

> Childhood family experience especially in the womb and in the early years, becomes "embedded in the biology of the individual and serves to influence health and capacity over the life span. A central mechanism of this process is epigenetics, defined as persistent and heritable alterations in genome information that do not involve change in DNA sequences themselves.[13]

Ensuite, les sciences neurologiques avancent que la multiplication des cellules nerveuses se fait en accéléré durant les trois premières années de vie pour ensuite

diminuer lentement et retrouver la densité de celle du nouveau-né à l'âge adulte. Se fondant sur cette observation, les experts extrapolent et affirment que cette période de 0-3 ans constitue une étape cruciale d'apprentissage qu'il est impossible de rattraper par la suite.[14] À cela s'ajoute l'établissement d'étapes spécifiques de développement qui requièrent des stimulations appropriées pour maximiser les capacités d'apprentissage et l'intelligence de l'enfant.

Finalement, que ce soit en matière de stimulation précoce (parler, toucher, chanter, jouer avec des jeux éducatifs, etc.) ou encore de climat familial (stabilité, affection, sécurité), les parents sont invités à offrir le « meilleur » à leur enfant. Conséquemment, un enfant qui naît et grandit dans un environnement non optimisé en ce qui a trait au contact physique, à l'affection et à la stimulation ciblée est considéré à risque d'en subir les effets à long terme. Ce qui a pour effet que les mères s'inquiètent (ou se sentent coupables) lorsqu'elles sont moins affectueuses ou plus anxieuses, ou lorsqu'elles traversent une période difficile à la suite, par exemple, d'un accouchement pénible, de problèmes d'allaitement, du stress lié à la précarité ou de l'exclusion liée à la pauvreté.[15]

Gouvernance néolibérale

Pour situer ces nouveaux savoirs d'experts dans leur contexte plus large, il est bon de se rappeler que depuis le début des années 1980, le modèle d'autorégulation que s'étaient donné les institutions privées - la « bonne gouvernance »- en vue d'assainir la gestion des fonds des investisseurs, a été reprise par les États. Derrière le discours louable de la saine gestion des fonds publics, s'installe en fait une gestion néolibérale étatique calquée sur le modèle d'efficacité de l'entreprise privée.[16 p11] S'ensuivent alors une série de mesures de contrôle et de surveillance, de coupures dans des services publics et d'investissements dans le secteur privé. Le corps public est désormais assuré par l'essor, la croissance et la compétitivité nationale et mondiale du secteur privé. Il s'agit d'une véritable révolution dans la conception du rôle de l'État.[16 p11-12]

Dans ce contexte où l'État se retire du soutien collectif de l'équité et de la justice sociale, les avancées des sciences neurologiques sont en parfaite cohérence et alimentent l'idéologie néolibérale dont les cibles d'intervention sont les individus (et leur famille). Responsables de leur sort, ceux-ci sont visés, avant même de naître, par des mesures qui maximiseront leur potentiel de croissance et de développement. Cette vigilance institutionnelle, bien que coûteuse, poursuit l'objectif de réduire la responsabilité et la charge de l'État dans la gestion des problèmes sociaux.[17,18] Ce façonnement idéologique de nos référents culturels -porter individuellement le poids de la responsabilité de sa santé, de sa réussite et de son bien-être (et ceux de ses enfants) pour ne pas porter le poids du jugement social et de la marginalisation[19] a été grandement facilité par la pensée du risque qui a transformé les sociétés industrielles durant la même décennie de 1980.

Logique du risque

La pensée du risque, articulée autour du double axe de la menace et du contrôle,[20] nous inculque l'idée d'une menace potentielle, à la fois omniprésente et rarement réelle, et donc de la nécessité d'un contrôle permanent. Les effets sociaux et politiques de cette logique sont nombreux. En ce qui touche le devenir parent, la notion de risque impose la multiplication des pratiques de dépistage justifiant une surveillance accrue et des interventions préventives auprès des mères enceintes, des nouveau-nés, des parents, des familles et des enfants. Ces pratiques renforcent l'idée qu'à partir de taux indicatifs de l'apparition d'un risque potentiel (ces taux fluctuent avec le temps et le développement de la biotechnologie),[21] il est possible d'établir des normes, de repérer les personnes qui s'en éloignent et d'intervenir auprès d'elles. Chaque personne est ainsi potentiellement porteuse du danger ou y particulièrement vulnérable. L'intervention se fait donc à ce niveau individuel. Quand il s'agit de la parentalité, le glissement anthropologique dans la signification du risque est majeur. Si d'entrée de jeu, de tout temps un parent a d'abord été considéré comme un protecteur, un éducateur significatif et indispensable, il tend aujourd'hui à être perçu comme un danger potentiel pour son enfant.[22,23] Et cela commence dans le ventre de la mère. L'enfant doit être protégé non seulement des maladies de la mère et de son bagage génétique, mais aussi notamment de ses habitudes de vie. Le poids pèse donc sur la mère, jugée inadéquate ou incompétente, par elle-même et les autres, lorsqu'elle n'arrive pas à donner à son enfant ce dont il aurait besoin pour son développement optimal.[24]

Pour éviter de mettre les enfants à risque de carences éventuelles et intervenir auprès des familles considérées comme « à risque », on définit la fonction parentale à partir de « compétences », de comportements à promouvoir ou à éviter. De nos jours, devenir parent ne s'apprend plus naturellement : il faut apprendre des « experts » si on veut donner le meilleur à son enfant. Cette notion d'apprentissage de la parentalité implique que les bonnes manières de faire les choses sont préalablement définies et cadrées en fonction de nouvelles normes sociales; et que le sentiment d'être un

bon parent repose en grande partie sur les connaissances formelles acquises en matière de parentalité.

Cette reconfiguration de la parentalité en des termes de prescriptions et d'obligations s'inscrit dans les pratiques de gouvernementalité propres aux sociétés néolibérales contemporaines (et les renforce). Elle engage les parents dans une démarche permanente de surveillance et de contrôle de leur manière d'être parent, parce qu'en dehors de ces normes, il est difficile de concevoir un « bon » parent, une « bonne » mère.

Amour, performance, contrôle et paradoxes : des normes parentales et du vécu des mères

D'importantes études sur la maternité ont clairement fait ressortir sa dimension duale, ambivalente, souvent contradictoire.[1,4,25,26] La présente étude n'y échappe pas. Au fil des récits se tisse une trame de tiraillements et d'ambivalences. Les jeunes femmes professionnelles que nous avons rencontrées travaillent à y mettre de l'ordre et à établir leur propre système de sens et d'action. Elles ont l'habitude de mener et d'organiser leur vie, et elles aiment en avoir le contrôle. Le choix d'avoir un enfant, la grossesse, l'accouchement et le postnatal les ont amenées à vivre une multitude de nouvelles expériences, de sensations et d'émotions. Elles ont été touchées, confrontées et obligées à faire des ajustements majeurs dans leur rythme (au sens propre) de vie. Si les tiraillements et les ambivalences n'ont pas disparu de la vie des mères au début du 21e siècle, les résultats de cette étude laissent entrevoir que les jeunes femmes actuelles négocient les normes contemporaines de la bonne mère en se positionnant comme l'auteure de leur propre vie.[27,28]

Documenter un point de vue : des contextes privilégiés pour devenir mère

Le présent article se fonde sur les résultats du volet qualitatif d'une recherche interdisciplinaire (sciences infirmières, psychologie, sexologie, anthropologie) sur la transition à la parentalité menée entre 2012 et 2013 dans un milieu francophone en situation minoritaire.

Les 14 mères de cette étude proviennent d'un milieu socioéconomique moyen-supérieur (64% d'entre elles ont déclaré un revenu familial de plus de 100 000 $ et 36% un revenu de 80 000 à 100 000 $) et bénéficient de conditions matérielles et environnementales avantageuses comparativement à la grande majorité des femmes du Canada et d'ailleurs.

Nous les avons rencontrées pour la plupart à leur domicile, où elles nous ont raconté, pendant une à deux heures, leur expérience de préparation à la naissance, d'accouchement et d'allaitement. Ces jeunes mères (âgées de 27 à 37 ans) jouissent d'un congé de maternité de près d'un an et plusieurs avaient même eu droit à une année payée à 90% de leur salaire. Elles occupent un poste permanent assortis d'avantages sociaux, y compris des congés de maladie pour soi ou pour s'occuper d'un membre de sa famille, des congés à traitement différé ou sans solde et des fonds de retraite. Un régime d'assurance-maladie collective rembourse les services de santé parallèles ou supplémentaires (psychologie, médecine douce, chambre de naissance privée). La plupart des femmes (13/14) partagent leur vie avec un conjoint qui est dans une situation de travail similaire ou presque. La plupart sont aussi copropriétaires de leur maison qui est située dans un quartier résidentiel de jeunes familles. L'endroit a été choisi en fonction de la proximité des marchés, des parcs ou des écoles pour que l'organisation de la vie familiale soit agréable et simple. La plupart ont des membres de leur famille ou de celle de leur conjoint dans la région. Ces personnes représentent pour les jeunes mères des ressources précieuses, tant pour avoir des conseils et un répit en toute sécurité que pour partager leur bonheur naissant.

L'attention portée à ce groupe favorisé de classe moyenne supérieure apporte un point de vue situé, rarement documenté, de parents qui ne sont pas, a priori, la cible des programmes et des interventions de formation parentale et de prévention précoce.[17] L'analyse requise a consisté en a) l'appropriation des récits des mères, enregistrés et transcrits, par de nombreuses lectures et relectures guidées par les thèmes centraux: la préparation, le déroulement de l'accouchement et l'allaitement ; b) en la déconstruction par l'extraction d'éléments significatifs récurrents et transversaux des différents récits; et finalement c) en la reconstruction des récits en des expériences de maternité, à la fois uniques et le reflet d'un milieu et d'une époque. L'analyse en mode d'écriture[29] a permis de rester au plus près des histoires vivantes des personnes et de s'en distancier par le constant dialogue avec les textes théoriques critiques.

La « bonne » mère …

…se prépare : devenir parent ça se travaille

Lorsque les femmes professionnelle rencontrées décident de devenir mère, elles s'engagent dans ce projet avec, pourrait-on dire, un souci de professionnalisme et même de perfectionnisme. Les propos souvent entendus « J'ai tout lu », « J'ai tout fait ce qu'il y avait à faire ») se confondaient

avec le sceau de la « bonne » mère. Tout au moins pour certaines, le fait d'avoir fait les démarches, était en soi un avancement positif et productif dans la maternité, un pas, à la fois incontournable et source de satisfaction.

> C. : Est-ce que tu avais le sentiment d'être prête pour l'accouchement?
>
> P. : Oui, parce que j'ai tout fait ce que j'ai pu. Alors moi, dans ma tête, j'avais fait ce qu'il faut faire avant d'aller accoucher…Je ne me serais pas vue aller à l'hôpital sans avoir fait ça. J'aurais aimé en savoir plus mais au moins je ne me sentais pas comme si je n'avais rien fait. J'ai fait ce que j'ai pu, pis j'étais correct avec ça. Mère d'un bébé de trois semaines

Par ailleurs, la préparation officielle à la naissance varie d'une femme et d'un couple à l'autre. La pauvreté des cours prénataux est un constat partagé par tous les participants qui ont fait des démarches pour en suivre. Certains parents déplorent le niveau enfantin des mises en garde : « Je me sentais au secondaire : faut pas fumer, pas boire, pas se droguer, bien manger, etc. » ; d'autres sont insatisfaits du contenu général et superficiel. Une série de cours prénataux publics qui était toujours offerte, quoique plus rarement en français, était composée de neuf modules à faire individuellement en ligne et de trois séances thématiques en groupe (accouchement, allaitement et parentage). Plusieurs y ont trouvé des renseignements utiles, mais la plupart déplorent le manque d'échange des expériences avec d'autres parents pour connaître leurs trucs : « comment ça marche dans la vraie vie ».

Quelques-uns ont choisi des activités préparatoires à la naissance offertes dans le privé : yoga prénatal, aquaforme, Bringing Baby Home qui a comme principe « Freedom of choice, knowledge of alternatives ». On y discute d'allaitement et du matériel nécessaire (sièges d'auto, couches, porte-bébé). Ce que les couples (2/14) ont le plus apprécié de cette formation est l'expérience de l'animatrice, mère de quatre grands enfants. En ce qui concerne le yoga prénatal, on y discute d'accouchement naturel et on s'y prépare, mentalement et physiquement. Certaines mères ont grandement apprécié la disposition « zen » face à l'accouchement qu'elles ont apprise, par contre, l'une d'entre elles déplore la dichotomie réussite-échec liée au recours ou non à la péridurale et à toute intervention médicale.

Pour avoir de l'information périnatale, les parents se tournent surtout vers Internet, les revues et les sites pour parents. Certaines ont mentionné la lecture de livres sur la naissance (Une naissance heureuse) (30). Lorsqu'ils ne savent pas quoi faire devant une situation, les parents cherchent les repères normatifs dans ces différentes sources, ils en discutent avec des parents de leur entourage, et ensuite ils font leur choix.

> Je pense qu'on est pas mal prêts...pis aussi avec Internet aujourd'hui, on peut vérifier n'importe quoi! Si on n'est pas certain, ce qui devrait arriver. On regarde deux, trois sources pis on se fait notre opinion pis on appelle nos mères Papa bébé de sept semaines

Étant donné l'absence ou la piètre qualité des services publics de préparation globale à la naissance, les prescriptions d'experts présentées hors contexte et glanées ici et là sur Internet deviennent les premiers savoirs auxquels les futurs et nouveaux parents ont accès. Il appartient à chacun de faire le tri. Peut-on parler de transmission de connaissances entourant un événement des cycles de vie?

…accepte : l'accouchement c'est d'abord une opération risquée

> On m'avait dit : « Tu vas voir, c'est comme si le corps veut te déchirer en deux, c'est comme s'il y a quelque chose en dedans qui veut te détruire. [Une mère]

Les parents reviennent plus d'une fois sur le manque de préparation « psychologique » (terme que plusieurs emploient) à l'accouchement. Les mères savent qu'elles vont avoir mal : « Imagine la pire des douleurs et multiplie ça par dix ». La plupart ne sont pas préparées à faire face à cette douleur. Certaines arrivent avec un plan de naissance qui inclut le souhait de ne pas recourir à l'anesthésie, donc de pouvoir bouger, utiliser le bain, prendre diverses positions pendant le travail. Elles se laissent cependant libres de changer d'idée suivant le déroulement de l'accouchement. Ces mères ont grandement apprécié le respect de leur choix par les infirmières et la présence aidante de quelques-unes qui leur ont suggéré des respirations et des positions pour faciliter le travail.

Toutes, sauf celle qui a accouché à la maison, ont demandé ou se sont vues offrir la péridurale et l'ont acceptée. Cette intervention a été précédée et suivie de plusieurs autres, parfois aux conséquences douloureuses pour la mère. Cependant, ce qui ressort des récits des parents, c'est que la joie de l'arrivée du bébé prend largement le pas sur les douleurs des déchirures au 2e, 3e ou 4e degré ou de la césarienne. La plupart ne considèrent pas l'accouchement comme une expérience en soi, mais plutôt comme un passage obligé pour avoir un enfant. C'est à l'arrivée du bébé que le déroulement chaotique et douloureux prend son sens.

Les parents n'estiment pas avoir un quelconque pouvoir ou marge de manœuvre dans le contexte hospitalier, surtout que les pratiques semblent toujours justifiées par l'évitement des risques pour la mère et surtout pour l'enfant. Ils ne contestent

pas les interventions. Un seul père, dont l'épouse a attendu la péridurale promise pendant cinq heures, a manifesté pendant l'entrevue son indignation « d'être traités avec une cruauté qu'on n'aurait pas envers les animaux ».

En matière d'accouchement, les récits des mères et des parents laissent à penser que la bonne mère accepte les intrusions dans son corps et la violence des interventions. Les marques qu'elles lui laissent semblent être le prix à payer pour mettre au monde un enfant.

> Je ne savais pas pourquoi, mais j'étais beaucoup déchirée. Alors probablement que les forceps ça aurait été pire. Ils sont allés la chercher avec la ventouse… ça a sorti avec la ventouse, mais j'ai fait une heure et vingt de poussée. Même si on a la péridurale, le corps est fatigué….Elle est née finalement. Ils l'ont placée sur mon ventre tout de suite en naissant. Ça leur a pris presqu'une heure à me recoudre. Je les entendais parler, ils disaient : Ça, ça va là, ça, ça va là…ça fait que j'ai des lacérations au 3e degré, pas loin du 4e.
>
> Enchaînant en s'adressant à son bébé : « Tu vaux la peine! Tu vaux la peine, pareil! Maman a tout fait ». Maman d'un bébé de 3 semaines

Pour plusieurs, ce sentiment d'avoir « tout fait » se conjugue paradoxalement à la déception ou à la culpabilité de ne pas « réussir » son accouchement (et plus tard, son allaitement) comme une « championne ».

> Le moment le plus difficile, c'est quand ils m'ont appris qu'elle avait besoin de ventouse pour sortir (émotion dans la voix). J'ai essayé de mon mieux pour pousser, pour essayer de prévenir d'avoir besoin de l'utiliser, pis j'ai pas pu. Ça j'ai trouvé ça…pas démoralisant, mais j'étais déçue de ne pas pouvoir la mettre au monde. J'ai fait un beau bébé, mais j'ai pas pu la sortir! La même maman

Que ce soit en lien avec le fait d'avoir perdu son calme, d'avoir eu recours à l'anesthésie ou d'avoir eu à subir une ou des interventions pour sortir le bébé, selon la sensibilité et du système de sens de chacune, il se dégage un sentiment de désenchantement des expériences d'accouchement. Et simultanément, cette déception se dilue dans l'acceptation incontestée des décisions médicales : « À une autre époque, je serais morte en accouchant ». Finalement, le fait d'être en vie et d'avoir un bébé en santé donne à l'expérience une issue heureuse. On tourne la page.

…s'adapte : l'allaitement c'est un meilleur ami exigeant

> C'est que c'est vraiment connu que l'allaitement est meilleur pour le bébé. Tout le monde le sait, tout le monde préférerait ça, je pense. [Une mère]

L'allaitement occupe une position centrale, voire hégémonique, dans les cours prénataux. Pourtant, selon les mères, quand ça ne se passe pas comme dans la théorie, le soutien en postnatal ne répond pas à leurs besoins. Les infirmières de l'hôpital, plus investies de la mission des *Hôpitaux amis des bébés* qu'à l'écoute des limites de chaque mère qui a des difficultés à allaiter, leur donnent un soutien relatif. Lorsque ça se passe bien, on reconnaît aux infirmières une grande compétence. Même si elles n'ont pas toutes le même discours ni la même lecture d'une situation, les mères rentrent à la maison avec des trucs de professionnelles expérimentées.

Pour les femmes qui veulent jouer leur rôle de mère à la perfection et avoir le contrôle de leur vie, l'allaitement est un lieu où l'ambivalence et le tiraillement sont le plus palpables.

Les jeunes femmes professionnelles sont informées et peuvent réciter par cœur la liste des effets positifs de l'allaitement. Elles ont également accepté la norme qui consiste à au moins essayer pour être considérée comme une « bonne » mère. Elles savent cependant que pour « donner le meilleur à son enfant », il est préférable d'allaiter au moins six mois et de préférence un an, selon les recommandations de l'Organisation mondiale de la santé (OMS).

Chacune des mères ressent la pression intérieure de tout faire pour « réussir », selon ce qu'elles ont assimilé de leurs lectures et des médias.

> Tout ce que tu lis, c'est comme une espèce de vision idéalisée de ce que c'est d'être mère, quand tu allaites. Il y a juste des avantages à allaiter puis il y a juste des risques à donner la formule

Puis s'ajoute la pression extérieure, exercée par les professionnelles de la santé

> Il y avait une fille qui était moins « allaitement » dans le cours prénatal. Moi si j'avais été à sa place, je me serais sentie comme une mère ingrate de pas allaiter. Maman d'un bébé de deux jours

et parfois par d'autres mères.

> Chez des amis une fois, il y avait une femme qui parlait de ses problèmes d'allaitement. Elle s'est faite presque attaquer par les autres mères parce qu'elle avait osé dire qu'elle considérait arrêter d'allaiter […] On l'a fait sentir « Ah quelle sorte de mère que t'es? » Une maman qui allaite pour un an maximum

Au début, la souplesse que cela demande et le peu de prise qu'ont les femmes sur leur horaire, sur ce que mange le bébé, sur le moment où il aura faim, où il dormira et où il se réveillera sont très exigeants pour elles. Les femmes rencontrées n'ont pas l'habitude de perdre le contrôle. Lorsque de surcroît l'allaitement est douloureux et inefficace parce que le bébé ne *latche* pas bien ou qu'il n'est pas rassasié, cette difficulté d'adaptation se transforme en une véritable souffrance dans

cette période de transition à la maternité.

Lorsque les mères cessent d'allaiter leur nourrisson (et avant de jeter l'éponge, elles traversent l'épreuve des crevasses, des mastites, du pompage de jour et de nuit, des pleurs d'un bébé affamé et du manque prolongé de sommeil), elles restent avec une impression de transgression (« elle n'est plus pure » se sont dit des parents après avoir donné le premier biberon) ou un sentiment d'échec.

> Je voulais réussir beaucoup beaucoup mais ça ne marchait pas...ça finissait en crise (s'adressant au père) Tu m'as convaincue d'essayer pis après c'est moi qui en faisais comme une espèce de bataille personnelle. Je suis perfectionniste, je voulais réussir pis ça n'a pas marché…Je voulais réussir pour le bébé. Une maman qui a arrêté l'allaitement après six semaines de tentatives

La plupart des mères qui allaitaient encore au moment de notre visite (de six à huit semaines après l'accouchement) en appréciaient la commodité (pas de préparation, pas de matériel à transporter, pas de risque de microbes, peu d'attente pour le bébé) qui facilite leurs déplacements. Certaines aussi rapportent les moments inestimables de connexion avec leur bébé, les partages uniques de regards et de sourires. Par ailleurs, tout cela n'empêche pas certaines de déplorer l'exigence quotidienne de l'allaitement.

> Fait que je pense que c'est ce qui est le mieux pour elle finalement. C'est mon devoir, je suis une mère maintenant. Mais moi, personnellement, MY GOD, c'est comme oublie ça là, je trouve ça exigeant! Une maman

> Ça dit que ça réduit les risques de certains cancers, supposément que c'est bon pour l'enfant, pour la mère, pis aussi que c'est pratique pis que c'est des dépenses en moins. Pis que c'est naturel. La seule chose qui me rebute, c'est MON DIEU, je suis dans une prison! Y as-tu quelqu'un qui peut l'enlever, j'suis plus capable! Une autre maman

En fait, la plupart sont tiraillées à divers degrés entre le grand bonheur de « réussir », de remplir leur devoir de « bonne » mère et celui de se sentir pognée, en prison, même. Néanmoins, la certitude des bienfaits de l'allaitement aura le mot de la fin : le plus beau cadeau que je peux lui faire c'est de lui donner mon lait.

Une réappropriation de la naissance

Agencéité

Les récits des mères (et des pères) renvoient à la nouvelle lecture de l'agencéité que propose Saba Mahmood. Selon celle-ci, l'agencéité ne se résume pas à contester le pouvoir et les normes en place, mais se définit comme « l'aptitude à introduire des changements dans le monde » […] Il est tout à fait possible d'articuler des changements en mettant en acte les normes existantes ».[31] Inspirée de la lecture de Judith Butler, elle rappelle que la subjectivation et le devenir soi se font dans les limites que posent les relations de pouvoir. Le sujet n'est jamais seul, il est le produit (et producteur) d'un ensemble de normes qu'il partage avec d'autres et qui délimitent son espace de liberté. Par ailleurs, comme mentionné en introduction, cet espace délimité peut aussi faire l'objet de contestations, de transgressions et de réappropriations. Lorsque Adrienne Rich relate son expérience de mère dans les années 1980, elle met en lumière son tiraillement entre l'amour pour ses enfants et la frustration et la rage qu'ils lui inspirent quand elle n'arrive pas, même juste un peu, à écrire la poésie qui l'habite. Elle parle d'elle-même et par le fait même des femmes de son époque.

Trente ans plus tard, la situation des jeunes femmes de 20-30 ans que nous avons rencontrées est tout autre. Elles se considèrent d'emblée comme des auteures de leur vie et comptent bien tout mettre en œuvre pour la bâtir en fonction de ce qui leur convient et de ce qui correspond à leurs aspirations. Elles se donnent le droit d'être ce qu'elles sont et de faire les choses à leur façon. Leur validation personnelle se construit dans l'espace public - dans un travail qui les épanouit et les valorise - et dans l'espace privé - dans une relation privilégiée avec un amoureux-ami qui les aime et les soutient.

Par ailleurs, ces femmes ont incorporé et fait leur un ensemble de prescriptions sociopolitiques qui régulent leur vie en général (compétitivité, sécurité, risque, performance individuelle) et ici, leur expérience de maternité. Elles exigent beaucoup d'elles-mêmes et s'attribuent individuellement la responsabilité des causes et des conséquences de leurs actions. Elles s'opposent peu ou pas ouvertement aux normes reliées à la parentalité : elles s'en servent avant tout comme repères (Qu'est-ce qui devrait se passer à ce stade-ci?) pour savoir comment faire.

En même temps, dans le vécu des choses, les nouvelles mères prennent conscience des effets de la pression de se conformer à des normes construites (en dehors de la réalité vécue) en fonction des barèmes de croissance du bébé, des ressentis prédits d'un amour instantané et des capacités à « gérer » zennement l'arrivée du bébé et les bouleversements qui l'accompagnent. Elles sont perfectionnistes, se rendent à leurs limites et ne se donnent pas l'étiquette de mauvaises mères.

Et c'est ici que la lecture de l'agencéité peut faire ressortir la position sociopolitique des nouvelles mères (et des pères). Elles souhaitent une plus grande transparence et déplorent la partialité de l'information, voire les mensonges qu'on leur raconte. Celles qui vivent des difficultés, et qui en parlent, se rendent compte que ce qu'elles croyaient anormal est dans les faits une réalité que plusieurs vivent. Elles ne croient pas les récits nirvanesques de transition à la parentalité. Elles constatent qu'il n'est pas facile pour les parents d'oser dire leurs limites et ainsi de s'exposer aux jugements des autres. Seulement, le fait d'apprendre que de « bons » parents de « beaux » enfants à leurs yeux ont vécu et vivent des moments de doute et de désarroi, et des sentiments d'incompétence et de culpabilité les apaise et normalise ce qu'elles croyaient être hors norme. C'est en lien avec cette réalité que plusieurs expriment leur besoin de rencontrer d'autres parents qui ont vécu la transition qu'elles traversent et d'avoir des échanges authentiques et sans jugement avec eux. Comme l'information factuelle est accessible à diverses sources, ce sont les véritables échanges d'expériences qui apparaissent être le meilleur canal de transmission des connaissances entourant le devenir parent. On peut facilement considérer ces lieux comme des prises de parole qui reformulent les discours dominants à la lumière d'une nouvelle autorité reconnue, celle de l'expérience vécue par des pairs. De manière implicite, en réclamant ces espaces, les jeunes mères (et les jeunes pères) affaiblissent, non pas nécessairement les fondements des discours des experts en santé et en psychologie, mais leur intrusion autoritaire, décontextualisée et sans nuance dans la vie de tous les jours.

Événement des cycles de vie et rite de passage

La naissance, dans une perspective anthropologique, est un événement des cycles de vie, et donc un site privilégié pour produire un ensemble de discours et de pratiques qui encadrent ce passage dans le sens que le souhaite une société à ce moment de son histoire. Celle-ci transmet par le fait même un ensemble de valeurs et de manières d'être et de faire qui assurent, d'un certain point de vue, sa continuité et sa stabilité. Ici les mères (et les pères) que nous avons rencontrées se réapproprient l'événement de la naissance pour reformuler un discours à partir de leur expérience de transition à la parentalité.

D'abord, les parents vivent l'arrivée de leur enfant comme une expérience humaine forte, voire spirituelle. De diverses manières, le fait de devenir parents et d'être responsables d'un petit être qu'on a mis au monde les inscrit dans une appartenance à leur lignée. Certains sont particulièrement touchés de prendre conscience de leur rapport à leur propre mère ou à leur propre père. Cette nouvelle sensibilité est une occasion de compréhension, de rapprochement et de guérison de leur passé d'enfant ou d'adolescent. Pour d'autres, c'est le rapprochement familial élargi qui marque le plus intensément ce constat aigu d'appartenir à un groupe, consolidé encore plus par leur apport d'un nouveau petit-enfant, neveu, nièce, cousin, cousine…Finalement, d'autres parents y voient le symbole de leur continuité, le legs de leur passage sur terre. Dans la culture dominante de l'ici et maintenant, du tout, tout de suite et ici, sous l'avalanche de chiffres qui comptabilisent les risques et la peur, ces jeunes parents nous rappellent que cette culture n'engloutit pas tout et que ces marqueurs de l'existence humaine restent toujours bien vivants.

Ensuite, ces couples de parents se décrivent comme des amis qui se disent tout et une équipe soudée dans l'action. La responsabilité parentale est concrètement partagée quotidiennement. Le conjoint est dans la grande majorité des cas un soutien fiable, un coéquipier, un complice aimant et compréhensif. Les pères qui y ont droit se prévalent du congé de paternité. Les autres vont prendre leurs vacances annuelles ou un congé sans solde pour être à la maison durant cette transition à la parentalité. S'ils sont confrontés à quelques réminiscences concernant les rôles des mères à la maison et des pères pourvoyeurs, ils les expliquent eux-mêmes par le machisme de milieux arriérés qu'il reste à éduquer. Lorsque certains pères sont gênés de sortir avec le porte-bébé, ce qu'ils font sans broncher à l'intérieur, ils y sont fortement encouragés par leur conjointe qui y voit une affirmation sociale du nouveau vécu parental. Et ces femmes savent trop bien que c'est par cette affirmation que passe leur liberté d'exister dans d'autres sphères que la maternité. Cela dit, pour toutes les femmes, la maternité reste globalement la priorité, et les choix importants à faire sont des choix familiaux.

Finalement, l'expérience de transition à la maternité des mères rencontrées peut se lire à la lumière de la théorie des rites de passage de Van Gennep.[32] Lors du congé de maternité (période de séparation et de transition) elles auront appris à nourrir et connaître leur enfant ; ces femmes auront aussi graduellement mis en place une discipline avec leur conjoint pour garder leur personnalité (individuelle et de couple!) et mener une vie équilibrée entre le travail, le sport, l'engagement social et les loisirs. Elles se voient relever des défis et grimper les échelons lors de leur retour au travail (la réintégration) -que toutes anticipent avec grand bonheur- tout en continuant de donner la priorité à leur famille.

Conclusion

Pour conclure, revenons à notre question de départ : Comment les mères concilient-elles leur expérience de la maternité avec les normes de parentalité contemporaines? Du point de vue intergénérationnel de femmes qui ont lutté pour l'humanisation des naissances dans les années 1980-1990 et qui ont vu l'institutionnalisation de pratiques redonnant aux mères, aux couples et aux familles le pouvoir dans les lieux de naissance, l'ultramédicalisation de l'accouchement est inquiétante. Les mères (et les pères) achètent sans broncher une surenchère d'interventions (et en payent le prix), convaincues qu'elles sont inévitables pour leur sécurité et celle de leur enfant. Il serait pertinent, à l'instar de nombre de chercheurs et de professionnelles de regarder de plus près les pratiques obstétricales.[33-37] Parler de violence obstétricale n'est pas inapproprié quand on écoute ce que racontent les mères participantes de cette étude. (Ce thème des interventions obstétricales fera l'objet d'un prochain article).

Sur un autre plan, les mères se servent d'une partie des discours autoritaires sur la parentalité comme repères et en laissent tomber une autre partie quand elles s'évaluent meilleure juge de leur équilibre et de leur bonheur personnel, conjugal et familial. Les mères qu'on a rencontrées sont loin des mères sacrifiées des années 1950-1960. Elles sont les auteures de leur vie, elles jaugent, voient leur intérêt et celui des leurs et s'organisent pour que la réalité corresponde le mieux possible à leurs désirs de bonheur et de réussite dans les sphères maternelle, professionnelle et personnelle.

Le tiraillement ne les épargne pas ; il serait même beaucoup plus puissant, selon certains auteurs, du fait du pouvoir accordé aux discours des experts qui façonnent la parentalité et la régulation maternelle qui en découle. Pourtant, les femmes résistent à se sacrifier pour s'y assujettir. Elles font le nécessaire pour rester dans la norme et lui tourne le dos quand leur équilibre et leur bien-être sont en jeu. Quand les choses dérapent, elles sont tout à fait aptes à analyser la situation en fonction de leurs propres critères, cette fois, pour reprendre pied. Voici ce qu'expliquait une jeune maman qui tentait de se déculpabiliser d'avoir arrêté l'allaitement après six semaines intenses d'essai : Pour l'avoir vécu, je sais très bien que quand ça ne fonctionne pas, il y a des risques à l'allaitement. Si la mère ne va pas bien, je ne vois pas comment le bébé peut bien aller. Il y a tout lieu de croire que chacune, avec la complicité du père, arrivera à se construire une vie de mère « puissantifiante ». Il ne reste qu'à faire en sorte que ce soit possible pour toutes les mères!

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Commentaire/Commentary

Recent Case Raises Hopes for Reducing Harm from Psychiatric Labelling: A Blow Against "Weaponized Diagnosis"

PAULA J CAPLAN & KADE PATTERSON

Harm from Psychiatric Diagnosis

A person can suffer a vast array of kinds of harm as a result of being labeled mentally ill.[1,2,3] The harm can range from plummeting of one's self-confidence to loss of a job or failure to get one to loss of custody of one's children to deprivation of the rights to make decisions about one's medical and legal affairs. Such labeling can be used as a way to discredit and silence those who speak out about matters that those more powerful than they wish to keep secret. In addition, once psychiatrically diagnosed, a person who has real physical illnesses, pains, or injuries may have those problems overlooked or dismissed as the imaginings of a person who is mentally ill. It is frighteningly easy to trample on a person's basic human rights once they have been classified as mentally ill.

As long as this labeling happens in places where sexism and other forms of bias and oppression persist, the damage will continue to be disproportionately done to those who are not male, white, heterosexual, reasonably well-off financially, neither very old nor very young, and able-bodied.[1,4] Especially troubling is that many therapists diagnose someone as psychiatrically disordered when in fact the behavior and emotions they classify as evidence of mental illness are the deeply human (even in important ways "normal"[1]) reactions to traumatic experiences such as being raped or being in a war zone. In some settings, as will be discussed, additional factors are breeding grounds of still other forms of harm. It is encouraging that recent developments in one such setting provide reason for guarded optimism about the possibilities for reducing the harm.

The fundamental issues addressed in this paper apply directly to anyone psychiatrically labeled in any country, although the primary, encouraging case example we present is about one of the co-authors (KP), who served in the United States Army. Once as massive and powerful an institution as the U.S. Army changes course, it is hoped that other institutions will follow suit. At best, recent action by the U.S. Army will turn out to be a harbinger of such a change.

Description of the specifics of the Patterson case will be presented, followed by discussion of some principles that apply to such cases both in and out of the military and also of issues particular to the military.

The Patterson Case

Kade (then known as Katie Leigh) Patterson had achieved a fine record of military service and was proud of being part of the U.S. Army since enlisting in August, 2004. Then in 2005, a sergeant sexually assaulted her on their base. In the U.S. military, victims who wish to report such attacks are required to do so within their chain of command, although that chain often includes the perpetrators themselves and/or people whose priority is to protect the reputation of their unit rather than seeking justice for the victims and appropriate punishment for the perpetrators. Patterson reported the assault within her chain of command, and the report went to the office of the Army's Judge Advocate General (JAG). An order was issued restraining the sergeant from coming near her. Patterson requested a copy of the JAG's file about the case, and the JAG refused to give it to her. She continued to do her work and did not seek help from a therapist at that time. The same year, while outside the base, she was again sexually assaulted. Immediately, she went to the nearest hospital – a civilian one – reported having been raped, and was interviewed and examined. At her request, the hospital gave her a report of this visit.

When Patterson learned that her second assailant had previously done military service, her deep-seated faith in the Army as an institution where people behaved with integrity was shattered, and for the first time in her life, she became frightened, agitated, and despondent to the point of thinking about committing suicide. She told her battle buddy how she was feeling, and when the battle buddy reported this within their chain of command, Patterson against her will was sent to a civilian mental hospital outside the Army base and told by the Army that she was not allowed to leave. Needless to say, servicemembers know they are expected to follow orders. She was placed in a padded room and given no support or counseling. She was put on five or six psychiatric drugs and does not recall what the drugs were but remembers sleeping almost constantly for the entire 30 days in the hospital. She does not recall anyone from the Army meeting with her during her hospital to stay to offer information, support, or counseling. She felt that she was having a normal reaction to trauma and had done nothing wrong but was being punished. She was held there without being given a formal hearing or told she could have one and was informed that she had to stay until she was no longer a danger to herself or anyone else. She had never considered harming anyone else. Although she must have been given at least one psychiatric diagnosis when admitted to the hospital, she does not recall being told anything while there about receiving any labels. When she later signed and sent forms requesting her records from that hospital, the reply she received was that her records were sealed and that she could not have them. It is not known whether the Army was given the records or who ordered them sealed.

Patterson was told that she was being released from the hospital because she was no longer considered dangerous. When she returned to the base, an enlisted woman in the orderly room who was not a counselor or therapist informed her that the Army was saying she had Personality Disorder with Borderline Features. Patterson does not know where that information came from, but she then saw a psychologist/lieutenant for 30 minutes, during which he asked her some questions, she tried to bring up the assaults, and he avoided discussing them and simply kept repeating that due to her self-harming behavior (though she had never made such an attempt), she was not adapting to military life and culture. Borderline Personality Disorder (BPD) is one of the most harmful of all psychiatric labels because of the serious impairments in many kinds of functioning that are said to characterize it, and women are far more likely than men to be given this diagnosis. [5]

Subsequently, an officer in Patterson's chain of command informed her that she was going to be discharged from the military, and when Patterson said she wanted to see a lawyer, the officer told her if she was unwilling to accept being discharged on the basis of her diagnosis, she would be dishonorably discharged. As a result, Patterson agreed to the discharge on the basis of the diagnosis, because it would be classified as honorable. Patricia Lee Stotter, a veterans' advocate and co-producer of the film "SERVICE: When Women Come Marching Home," coined the term "weaponized diagnosis" to describe exactly this kind of use of psychiatric labeling to blame and otherwise harm victims of sexual assaults and other kinds of trauma [6]. The term is

applicable to people who are treated this way in the civilian world as well.

The U.S. Army has a Board of Appeal for Correction of Military Records (ABCMR). In 2013, Patterson first learned about the existence of this Board after being in touch with other survivors of military sexual trauma and then searching online. That year, on her own, she appealed to that Board to remove the personality disorder basis for her discharge. She provided documentation that she had had no history of emotional difficulties before the assaults and that being upset because of being attacked does not warrant a diagnosis of mental illness and certainly not of a personality disorder. The Army rejected that appeal, saying that its own physician did not believe that her documentation warranted removal of the diagnostic label. There were many troubling aspects of the physician's opinion, including his lack of access to the full information and his unwarranted inferences. For instance, he cited the fact that Patterson had been prescribed powerful psychiatric drugs after the assaults as indicating that she was mentally ill, with no sign that he had considered the possibility that she was not mentally ill and that the drugs were unjustifiably prescribed. He also presented as a concern that Patterson "fired" a VA therapist who doubted the veracity of her report that she had been sexually assaulted, when in fact it is not just appropriate but actually advisable for a patient to stop seeing a therapist who would do that. According to Patterson, she stopped seeing that psychologist after giving her a copy of the official report of the second rape that was prepared at the off-base hospital near where the assault occurred, and the psychologist, after accusing her of having created it on her own computer, actually ripped it up. Furthermore, this same therapist had done no evaluation of her own but told Patterson she had a personality disorder because the Army had decided that she did.

In 2014, this time with assistance from attorneys with whom she had been connected by Protect Our Defenders — which advocates for victims of sexual assault in the military, Patterson again appealed, adding still more documentation of her excellent psychological functioning previous to the assaults. Ten years after her discharge, in a groundbreaking reversal, the ABCMR in March, 2015, granted her appeal, removing the personality disorder diagnosis as the reason for discharging her. As her attorneys requested, the discharge reason was changed to "Secretarial Authority," which indicates that her release was part of downsizing by the Secretary of the Army.

Despite the primarily positive move, the Army's recent decision is somewhat problematic. First, her counsel had noted that Patterson had been a victim of sexual assault, but the Army's section about reasons for their changed decision fails to include mention of that, referring only generally to her having experienced "a traumatic event," which might be taken to mean the one in which she sustained traumatic brain and knee injuries. Curiously, the decision includes in one sentence the contradictory statements that she "had developed a personality disorder," although by definition that does not happen in adulthood, and that as the result of that disorder, she had problems "that began prior to service." In addition, a counselor Patterson saw at the Vet Center wrote to the ACBMR that Patterson does not have a personality disorder but instead suffers from PTSD secondary to the sexual assaults. Although it is certainly true that Patterson suffered as a result of the assaults, it is problematic to diagnose her with PTSD, given that PTSD is an official psychiatric disorder, so the Vet Center counselor was simply applying a different psychiatric label to Patterson's normal reactions.

The ACMBR has a website on which 13 cases were located of women sexual assault victims who had been diagnosed with BPD and discharged on that ground and who requested removal of that reason for discharge. [8] For only two has that request been granted. Patterson's is the more recent of those two. A similar ABCMR decision changing personality disorder to Secretarial Authority as the reason for discharge of a sexual assault victim [9] was made less than one month after the Board's 2013 rejection of Patterson's first appeal, and it is unclear from their written decision why the Board took almost two more years to make the change for Patterson. When they were asked to explain why this was, they refused to reply.[7]

When asked why no mention is made in the Discussion and Conclusions section of the Board's March 10, 2015 decision of Patterson's statements about having been sexually assaulted in the military, the Army representative's reply was that the reasons for the decision would not be discussed, that "the collective reasons by the ABCMR panel" are contained in the document about its decision, and that "To comment beyond the Record of Proceedings would be speculative and intrude upon the deliberative process of the Panel." [7] In this regard it is relevant that investigative journalist Alissa Figueroa has shown massive and blatant problems with the ACBMR's procedures, including that they do not read much of what appellants submit and that they spend an average of three minutes and 45 seconds on a case before rendering their decision.[10]

Crucial Issues: Unknowns and Injustices

Psychiatric Diagnosis Is Unregulated. It is impossible to know how many traumatized people in or out of any military or civilian system have been labeled mentally ill on the basis of the emotional or behavioral effects of trauma and have suffered harm because of receiving those labels. At the most general level, this is due to the rarely-discussed but important fact that psychiatric diagnosis is entirely unregulated. The two primary diagnostic manuals – the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*[10] and the World Health Organization's *International Classification of Diseases* ([11] the latter of which includes a psychiatric section that is intentionally similar to the contents of the DSM) – are created by committees deliberating largely in secret. Nine complaints filed with the APA's Ethics Committee about devastating harm done to individuals by the use of DSM labels and the false advertising of the DSM as scientifically based were curtly dismissed by that Committee on highly spurious grounds and with no attention paid to the merits of the cases. [13, 14] Five of those complainants then filed with the Office of Civil Rights of the U.S. Department of Health and Human Services, alleging that they had been discriminated against pursuant to the Americans with Disabilities Act, relative to the provision prohibiting the treatment of people without disabilities as though they have disabilities. The complainants had experienced events ranging from deeply troubling to horribly traumatic, and their reactions to those events – as with Patterson – were used to diagnose them as psychiatrically disordered. Those complaints were also dismissed on patently unwarranted grounds, again with no attention to the merits of the cases. [13, 14] And attempts even to find out whether the World Health Organization has a committee with whom such complaints can be filed have been met with stonewalling. [15]

Scope of Harm is Unknown. One consequence of this lack of regulation both by the APA guild and the U.S. government entity that ought to provide oversight and act on complaints about harm is that no central, accurate recordkeeping of who gets diagnosed and with what label exists. And although the nine complainants in the APA cases requested that the APA actively begin – as drug companies have been ordered to do in the U.S. – to compile records of harm from their product, the DSM, they have not done so. The APA might consider using some of the $100 million earned from the DSM-IV to gather this information.

It is impossible to determine how many sexual assault victims in or out of the military have had their normal upset classified either as any psychiatric disorder or specifically as BPD. Outside of the military, there is no central system of such records, and between 2001 and 2010, the military discharged more than 31,000 servicemembers on the basis of their having been diagnosed with personality disorders of various kinds, but the military has refused to release information about the "scope and nature" of these cases.[16] The Army specifically has written that it does not have data to show the specific reasons for discharge in cases that are appealed to them.[7]

Furthermore, Patterson's experience with the psychologist who changed the subject when she tried to talk about having been assaulted remains all too common in both the military and civilian realms: Despite decades of work beginning with Second Wave feminists who began to speak out about sexual violence, intake forms and inpatient and outpatient charts – in the civilian world as well as in the military – too often include little or no mention of such trauma as causes for upset. Some therapists remain unwilling to address or even allow patients to discuss sexual assaults, and many are inclined to pathologize normal reactions to such assaults. In something of the same way that Patterson's Army psychologist considered her upset a sign of her failure to adapt to Army culture, some civilian therapists pathologize victims who remain upset beyond the time that the therapist deems they should have "recovered."[17]

The Public and Professionals Are Unaware of the Facts about Psychiatric Diagnosis. Another consequence of the lack of regulation is that much of the public across the globe and even surprisingly many therapists and other professionals are unaware of the solidly-documented facts that psychiatric diagnosis is almost entirely unscientific, that applying the labels does not reduce the suffering of those who are so labeled, and that getting a label carries many risks of harm.[1,13,14] As a result, like most people in a mental health system, Patterson was unaware of these facts and therefore in no position to challenge either the fact that she was diagnosed as mentally ill or the specific label she was given.

By definition, personality disorders are considered lifelong conditions, but despite Patterson's history of excellent functioning before the assaults, not for many years did it occur to her to challenge her diagnosis. In this respect, she is similar to most people who have this series of experiences. This is because therapists are so widely assumed to be experts who are making scientifically-based judgments and implementing scientifically-validated treatments.[13,14]

Furthermore, going through the assaults, the further trauma of the ways she was then wrongly treated and not given the support and understanding that would have been appropriate and helpful, then being discharged from the military she loved left her for many years too stunned and too busy totally reorienting her life even to explore if or how she might seek redress.

Procedures and rules specific to the U.S. Army made it impossible for Patterson to obtain essential documentation for her appeals, but many people in the civilian world in many countries have found met with long delays and even denials when they have requested their mental health records. This has quite likely reduced the numbers of people who have ever formally or informally asked any practitioner or representative of a clinic, hospital, or other entity to remove a psychiatric diagnosis from their files.

Problems Specific to the Military. Nancy Parrish and Paula Coughlin of Protect Our Defenders have written: "Instead of assuring victims that their distress about their attacks is a normal response, the Department of Defense (DoD) has a record of mistreating victims by labeling them with errant diagnoses of personality or adjustment disorders. Based on these diagnoses, victims are not only further stigmatized, but often discharged without benefits or health care".[18] They also note that although since 2001, more than 31,000 servicemembers were discharged based on PD labels, [16] in fact the Army, Navy, and Marine Corps "do not properly track mental health discharges."[19]

In 2012, U.S. Congresswoman Jackie Speier proposed a legislative amendment that would have directed the Department of Defense (DoD) to review the cases of people who were discharged from the military since 2001 on the grounds that they had been labeled with personality disorders, and it has been proposed that Adjustment Disorder diagnoses also be reviewed, since both are applied to sexual assault victims.[20] At issue for Speier was that cases of military sexual assault were then and are still very rarely being prosecuted[17] and that the Congresswoman had heard from many victims who not only saw their perpetrators go unpunished but who had themselves been retaliated against by being labeled mentally ill and suffering further because discharges on that basis made them ineligible for compensation and services.

This proposal was groundbreaking, but action needs to be taken against more than these two categories of diagnosis, because the kinds of harm described at the beginning of this commentary can come to a person who receives any psychiatric label. In some respects, the personality disorders are the most damaging labels for military veterans, because some substantial benefits are granted only to people with what are called "service-connected" problems, those resulting from or occurring during military service. The Adjustment Disorder (AD) category, although not classified as a personality disorder, constitutes labeling the person as having an abnormal response to what has happened to them; this is precisely because AD is officially considered a mental illness because of its listing in the diagnostic manual. Many other victims – of sexual assault, of war trauma, or of other kinds of trauma – receive any of a wide variety of other psychiatric labels, all of which involve calling normal reactions pathological. This includes Acute Stress Disorder, Major Depressive Episode, Major Depressive Disorder, Generalized Anxiety Disorder, and the extremely frequently-used Post-traumatic Stress Disorder. By virtue of their appearance in the manual, each of these is used to convey the inaccurate and harmful message that the traumatized person should not have been affected by the trauma.[17]

It is noteworthy that a 2015 Yale Veterans Clinic report[16] had shown that when, beginning in 2007, the military was criticized for using PD labels to deprive people of benefits and services, their use of those labels dramatically declined, but at the same time, their use of the AD label skyrocketed. In the Army, for instance, since 2008, as the numbers of PD discharges declined from nearly 1,000 previously to just over 300 per year, their discharges based on AD skyrocketed to 2,000 per year. All psychiatric diagnoses need to be included in such counts.

Is the "PTSD" Diagnosis a Good Solution?[21]

Patterson and other trauma survivors – in both the civilian and the military realms – have been advised to try to get their other psychiatric labels changed to "Post-traumatic Stress Disorder." There are three reasons for this. One is that getting that label seems an improvement over what seem to be more serious-sounding labels and that the inclusion of "trauma" in the title suggests that there is a reason other than a diseased brain for their feelings and behavior. A second is that getting that label can be a way for them to receive benefits if they can show that the trauma occurred during their military service, and a third is that the label qualifies them to receive certain services. With regard to the first, their relief about being diagnosed in a way that seems to be less damning – and less permanent than a personality disorder in particular – often understandably leads them to being unguarded about the other kinds of harm that can result from getting any

psychiatric diagnosis. With regard to the second, of course people harmed in the military should receive benefits, but being psychiatrically diagnosed should not have to be the way they get those benefits; the fact that they are suffering from what happened should be sufficient. As for the services to which the PTSD label (and others) can help them gain access, the rampant problems and delays in services from the VA are widely known, one of the two most common services – psychotherapy – is sometimes but often not helpful, and the other most common treatment – psychotropic drugs – has been shown to be helpful to some people but to do more harm than good. [22]

PTSD is as official a listing in the diagnostic manuals as anything else therein. [21] When it first went into the DSM, it included a statement to the effect that these were normal reactions to abnormal experiences. That was rather bizarre, because if the criteria listed for "PTSD" were normal reactions, then what was the label doing in a manual of mental illnesses? But at least that sentence made it possible for people who got the diagnosis to consider that they were not mentally ill, that they should not have "gotten over it" by now. Stunningly, in the 1994 edition of the DSM,[23] under the stewardship of DSM-IV head Allen Frances, that sentence was simply removed.

Before the term "Post-traumatic Stress Disorder" was created after the American war in Viet Nam in a well-intended attempt to draw attention to veterans' suffering, the other terms to describe war had each included a word that accurately represented the cause of the suffering: The term used in the U.S. Civil War was "soldier's heart," and others have included "war trauma," "combat stress," "shell shock," and "battle fatigue." The first word of PTSD is vague and certainly downplays the role of war in causing trauma. The same is true when "PTSD" is applied to a victim of sexual assault, who would more accurately be described as suffering from "rape trauma."

As for the "S" in "PTSD," the word "stress" is used to apply these days to everything from worry about being a few minutes late for an appointment to devastating experiences. What traumatized people experience tends to include some or all of the following: grief, terror, loss of innocence, shame, powerlessness, and despair.[21] To call those "stress" is both overly general in a way that is unhelpful to the labeled person and those who want to help them and minimizing of the suffering.

The "D" in the term applies the official stamp that makes it a mental illness.

Are There Reasons for Optimism about the Future?

There are reasons for concern but also some reasons for optimism about the future for people who are diagnosed as mentally ill because it upset them to be sexually assaulted.

Reasons for concern across the civilian and military realms include:

- the widespread belief that psychiatric diagnoses are scientifically-derived and applied, are helpful, and are not harmful
- the common tendency for people – both the public and many mental health professionals – to believe the myth that emotional problems are usually or always caused by chemical imbalances or defective brains and thus need to be psychiatrically diagnosed in order to be effectively treated
- the fact that devastation and a sense of powerlessness and shame can result from being sexually assaulted and also from being classified as mentally ill, thus reducing the chances that victims will challenge – or even wonder about – being diagnosed or be able to try to undo the harm that results
- the public's lack of awareness of how to get a diagnosis removed from their records, combined with the paucity of attorneys who assist with such efforts

A primary reason for concern within the U.S. Army is their statement that "as an Agency, we cannot provide advice to any applicant in any case for maximizing the chances for a successful outcome." [7] Although they would likely justify this statement by saying that would be tantamount to any court giving advice to people about how to win their cases, the fact that few military servicemembers and veterans even know of the existence of military boards of appeals for correction of records, never mind what they should include in an appeal and the difficulty of finding attorneys to represent them, combines with the boards' apparent freedom to conduct their business according to their own, undisclosed rules and procedures to stack the deck against appellants.

In both the military and civilian realms, one way to consider the future is to list some changes that could help reduce the harm that comes to sexual assault victims who are psychiatrically diagnosed and then suffer harm as a result. These include:

- educating the public and professionals about the facts that psychiatric diagnoses are unscientific, largely

unhelpful, and often harmful[1,13,14,24][i]

- calling the public's attention to the ways that our world has become "psychiatrized" to the point that deeply human reactions to trauma that should by no means be labeled as pathological are often labeled that way[1]
- encouraging attorneys around the globe to represent those who have been harmed by psychiatric diagnoses in seeking to have the labels removed from their files and various forms of harm redressed
- holding U.S. Congressional hearings and hearings by legislative bodies in other countries about psychiatric diagnosis as an important step toward creating systems of oversight and regulation
- widely publicizing the important 2015 press conference by Human Rights Watch about the virulent forms of retaliation in the U.S. military against sexual assault victims who report the attacks, with the pathologizing of them as mentally ill named as one of the key forms[25]
- implementing careful oversight and wide publicizing of the decisions of military boards of appeal that deal with these cases and informing military servicemembers of the existence of these boards

These are only a few of many possible steps that would have significant impact on preventing harm from psychiatric diagnosis and letting those who have been harmed know what can be done to help them get justice. The Patterson decision paves the way for a sorely-needed look at the use of psychiatric labels to discredit people, cause them material harm, and deprive them of their human rights.

Notes

[i]Although U.S. National Institute of Mental Health Director Thomas Insel in this essay sharply criticizes the DSM system, the different system he vigorously promotes here is also profoundly flawed.

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