Yale Conferences and Events

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Mental Health, Captivity, and Liberation

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[Parallel sessions 3]

[Session 3A:

Speaking for Ourselves: Black Psychiatrists’ Activism Against Racism from Integration to Black Power - Simone Dreux

Psychiatry's Carceral Imaginaries: Lessons from Science and Technology Studies - Andy Wen, Taiwo Alonge]

Speaker: Welcome back to RebPsych 2022. You are welcome to send any technical questions to the host through the chat located at the bottom of your screen. If you would like to submit a question, please do so in the Q&A panel. This session is being recorded.

Speaker: Hello everyone and thank you to another session of RebPsych. I am a 4th year medical school here at Yale. I'm excited to introduce our next session.

We have closed captioning available for those of you at home. Select the live transcript or CC button. Select "show subtitles" to see closed captioning. If you have any other access needs, please let me know.

This session will be split into two presentations. I'm excited to present our first speaker, Simone Dreux.

Simone Dreux is currently a first-year medical student at Columbia University Vagelos College of Physicians & Surgeons. She graduated from Harvard College in 2020 with a bachelor's degree in History and Science (focusing on Medicine & Society), receiving magna cum laude with highest honors.

She completed her senior thesis on the history of Black psychiatrists' anti-racism activism efforts in the 1960s and 70s, for which she received the departmental thesis award in her graduating class. She then spent two years working in healthcare consulting before matriculating to medical school.

She is very interested in pursuing a career in psychiatry, as well as the intersection of mental health, health disparities, and social justice.

I am excited to have her take the stage. Her presentation is Speaking for Ourselves: Black Psychiatrists’ Activism Against Racism from Integration to Black Power.

Simone Dreux: Are you able to see that? Great, I will be talking about Black advocacy efforts through the civil rights and Black power eras, focusing on how they drove the dialogue on racism's impact on mental health during that time period.

I want to preface that this is mostly theoretical research and it focused on Black psychologist experiences instead of patients. This is a product of whose historical voices for more readily available.

There are many questions that this specific research did not answer but are worth asking. I'm glad to be here with you since I submitted this research right before the pandemic started in March of 2020. I'm excited to be able to engage with it again.

To begin the story, in 1969, a group of Black psychiatrists came together to protest the APA during their annual meeting. They demanded more Black leadership in organized society, specific the APA and NIH. They also wanted more focus on Black communities.

This was unprecedented and heavily politicized. This is shown in the news journal of the APA. It made a headline of a *New York Times* article. It was a moment that garnered people's attention.

I found out about this protest in a history of psychology class and didn't find much information on why it happened. I wanted to find out how and why Black psychiatrists become involved in anti-racism advocacy.

My primary question was how and why Black psychiatrists’ advocacy strengthened over time, particularly throughout the 1950s and 70s. How did they get to this point?

Antiracism advocacy started decades before this. They took on the political goals of the time period they were working in. I divided the time period into three chronological chapters, the 50s, 60s, and 70s. I found that Black psychiatrist advocacy moved with the political tide.

In Black power movement, they focused on dismantling power structures.

To start with the 1950s and characterize this era, I wanted to use a specific research paper as a case study for the ways Black psychiatrists engaged with race. There were two psychiatrists who published "The Mark of Oppression: a psychological study of the American Negro." They aimed to understand how Black people's low social status, referred to as caste in their paper, impacted their personality. The book claimed to be empirical and not theoretical. They said their data derived from a "new source material," the Negro himself. It's worth noting these psychiatrists are white men.

They studied African Americans in Harlem from the lower and middle class. They compared it to their control group of the American white man. To summarized their research, they said that the lower class Negro personality was characterized by maladaptive characteristics.

They called this the mark of oppression. The mark of oppression was the history of slavery. They said the only way to end these psychological impairments of Black people was to end racial oppression. In response, some Black psychiatrists and other professionals published opinionated reviews of this study. This NMA as started when Black physicians were not able to publish in other places.

A scathing review was written of "The Mark of Oppression." This triggered a discussion in the NMA. It was published in 1952. The Black psychiatrists who contorted to this renamed here. They criticized the methodological flaws and delved into the psychology of Black people.

When discussing medicine and the intersection of socially sensitive topics like race, they said that Collin's paper raised a question in my mind of contracting the damage from this book. Rather than stopping this research, they advocated for more sensitivity and methodology for research on the Black community.

Black psychiatrists were often not the ones publishing on racism. This was a bit of an anomaly. Since Black psychiatrists had to struggle for acceptance, and there were so few of them in this white dominated field, their voices are missing from this literature.

In addition to having to combat the racism from their colleagues, Jim Crow impacted their ability to practice medicine through segregated hospitals. They fought segregation to better serve their patients.

There was a Black psychiatrist that looked outward and tried to get the APA to advocate for desegregation during the *Brown v. Board* trial. The APA discouraged him. He was advised to withdrew from involvement and be aloof to the issue. One leader described the proposal of a continuation of him acting out. This discussion was limited for a variety of reasons.

In the 60s, a more dominant role was taken by Black psychiatrists in studying racism. There was also the increased momentum of the civil rights movement. Black communities were helped against segregation in the community, such as the Civil Rights Acting making it illegal to receive funding if hospitals were segregated.

Some got involved before their careers started. For example, there was Dr. Jeane joining the Freedom Rights. Others joined the Medical Committee for Human Rights. They came together to provide medical care for civil right workers in Mississippi.

One of the most famous was Dr. Alvin Poussaint who became nationally known in psychiatric work and *Jet* and more. They contributed to this body of literature they weren't initially able to drive. It was driven by white psychiatrists like [names here].

Black psychiatrists were dominating. Most Black psychiatrists’ literature contributed about race and that integration was mental health necessary. Dr. Hughes placed an article on segregation and Black children. They brought psychiatry to justify the movements of the participants.

There were people trying to pathologize the movement as well. They used the sound mental health of protesters saying it was the social system that was the problem. Dr. Pinder also published a paper about preventative psychiatric problems where he talks about this exact issue.

Black psychiatrists were now sort of leading this literature here. Pictured on this slide is an advertisement from Dr. Jeanne Spurlock that spoke to the direct public by giving lectures in Illinois to get on board of the social issues with integration. Advocation was centered around integration. It was the agenda of the civil rights movement.

In the 1960s the Civil Rights Movement is beginning to fragment. Race relations were not getting better. As we know integration led to violence and race riots in cities. In his 1968 address Dr. Martin Luther King Jr. said the decade of 1955 to 1965 misled them, they didn't realize how much violence would occur.

Nonviolence was not seen as enough to get rid of entrenched racism. As a result, there was the Black Power Movement. In 1967, Carmichael later known as [name] and Charles Hamilton defined power in their book here on the left.

[Stokley Carmichael & Charles V. Hamilton, Black Power]

It called for Black people to make their own organizations and support them. They coined the term "institutional racism" we are familiar with but was unknown at the time and also to Black psychiatrists in the 60s. They defined it as legal systems that kept Black people impoverished and not receiving healthcare.

This evolving Power Movement and new concept of racism impacted the change in the direction of what Black psychiatrists were researching and discussing. As the Black Power Movement gained popularity and there was frustration boiling over in cities black psychiatrists embraced the "do it yourself" framework.

They came together as Black mental health professionals to improve race relations in the country. At the 1966 NMA meeting in Chicago Dr. Charles Wilkinson wanted to assess how interested other NMA psychiatrists would be in forming a study group, believing they needed to organize more rigorously.

At the next NMA conference there was even more interest. Wilkinson took the lead of organizing this organization for psychiatrists that were Black and interested in advocating these issues. They advocated more Black leaders in NMA which they said was infected in institutional racism.

They thought NMA had more effects on Black Americans than any other medical institutions. They wanted to build new institutions and gain power back to bring to their communities. By the late 60s their publications began to circle back to look at the racial research in the 50s and 60s.

This included what I spoke about early *The Mark of Oppression.* Now it is read in a different light. Instead of being grateful Black issues were addressed, the racism that was institutional caused NMA psychiatrists to ask about the authority of psychiatric researchers themselves.

In review of the current literature on Black mental health, one writes [Reading quote: . . . through an outside source that may be naive].

She is one example of the NMA psychiatrist trying to apply this to the research for mental health.

There was a small grant given to Dr. Wilkinson to fund the groups meanings as they tried to address racial tensions. In February 1968 it took place, and in April 1968 was their first meeting. On the night where they were meeting, almost simultaneously, Dr. King was killed.

The organizing spirit, as I have been describing, was already present in this group for a few years. Many of the psychiatrists who attended that meeting in April remember Dr. King's assassination as a catalyst to bring action and change. And so. Dr. James Comber [sp?] who I personally interviewed remembered it as a reckoning that Black mental health needs were not met.

He said the anger in the streets made them realize they weren't addressing mental health issues and psychiatry was not addressing mental health and did not expect it to be inclusive, so they wanted to take action.

This excerpt on the slide is taken directly from the quote from the group on April 5th. It says,

[Reading: . . . but to burn and destroy are the kinds of release of rage and frustration when people don't know where to turn.]

On the bottom it is hard to see but it is the names of the Black psychiatrists who signed it and were there for that moment.

A month after Dr. King's assassination they were asked to speak at Black Power session of the APA. This was the first time they were invited. These are pictures from the meeting I found on the archives at Washington DC. They criticized openly the NMA of not doing enough to address racism institutionally and needs of Black people.

Going left to right here you can see Dr. Charles Wilkinson, the founder or initiator of the study group. Dr. Alvin Poussaint, one of the most famous nationally known psychiatrists who wrote articles in *Ebony* and *Jet* in a more public form. And Dr. Charles Pierce most well known for coining the term "microaggressions" later on.

One of the most impactful papers was presented by Dr. Charles Pinderhughes for the Black Power Movement. Instead of integration that they were talking about he is talking about how integration could only occur if white people understood the way Black people were socially undermined.

He described the Black Power Movement as a psycho-social treatment in saying,

[Reading: . . . then you can develop more trust and bonds and cooperation to make peer relationship between Black and white people possible for the first time.]

That's what he said. We see Black people defending the Black Power Movement with their colleagues. This brings us back to where we started in May 1969.

After an amicable but not successful meeting with the president of the APA, they decided to protest the annual APA meeting. On the evening of May 9th, 1969, the group in Miami held a meeting for an election on what they called the Black Caucus, the term for their study group. They compiled the Caucus' list of demands for the APA.

The Caucus presented their 10 demands to the APA. It included having a task force for the APA so they could better serving the Black community, put Black leadership in charge of research programs, increase funding for Black community programs in the NIMH. [Reading quote at bottom of slide]

During the course of these deliberations, the Caucus also formed a new organization called the Black Psychiatrists of America. They would remain under the APA through the Black Caucus, but they wanted their own organization to advocate for the causes they deemed important without the limitations of being associated only with the APA.

Now there is this question of the protest and having a new organization. What happened next? In the early 1970s, immediately after this protest, there was an increase in the number of Black psychiatrists in APA committees. They also took more leadership roles in other psychiatry organizations. Dr. Pierce was the first president of the BPA. Not all of their demands were met. Members of the APA were worried about this organization becoming too political.

The group was still resisting this tradition of putting white psychiatrists in the role of the Black expert. Their criticism of white driven psychiatric research drove them to create new research institutions outside the APA. They were run by Black psychiatrists and made to study issues in the Black Community. These include the Center of Minority Mental Health and the Solemn Fuller Institute. I found this check that helped in the founding of this institute.

They are both focused on developing minority mental health programs and recreating members to the NIMH. This focused on other minority groups, not just Black psychiatrists.

They continued the trajectory set by publications in the late 60s. NMA journal articles reflected Black psychiatrists reinterpreting the meaning of Blackness in their field. They didn't focus on civil rights and the damage of segregation. They focused on what it meant to be Black and practice psychiatry along with treating Black patients. They refuted some old paradigms to normalize Black people's behaviors in ways that would have previously been considered pathogenic.

Dr. Jeane Spurlock emphasized the strengths of the Black family. She said matriarchal families have positive and not just negative aspects. The mental health of Black children was a particularly strong area of focus both within and outside the APA.

For specific projects, one of the BPA's areas of interest was regionally mass media since Dr. Pierce felt it was a great purveyor of microaggressions. One of BPA's projects was teaching children how to identify them. Dr. Pierce was a member on the national advisory board with *Sesame Street* to be this intervention to show Black children and Black people, along with people of all races, interacting in a positive way. They felt the media could have a strong impact on improving race relations.

Some Black psychiatrists focused on developing Black leadership outside psychiatry and focused on community psychiatry. One of those psychiatrists is featured here, Dr. June Jackson-Christmas. He founded the Harlem Rehabilitation Center. It trained local Harlem residents, not just physicians, to assist psychiatric patients in getting back into society.

There are many ways Black psychiatrists tried to implement this Black Power vision throughout the 70s.

This picture was taken in 1978. The captured the members of the APA's Black Caucus and BPA, since many were in both organizations along with the NMA. This was the first and largest documented group picture they had taken together. It showcased the powerful and vocal presence that Black psychiatrists created for themselves along with in new Black run organizations.

Whether they were working together or separately, they all have the common political goal of reconstructing the profession, so it is better served by and for Black people in the US. This is a quote from Dr. James Comer, describing the importance of having the BPA.

They were able to put pressure on psychiatry in a way that would otherwise not have happen. The BPA logo is on the bottom right.

Although the specific social movements mentioned here have ended, racism is far from over, obviously. That is both in the medical field of psychiatry and in society broadly. On the left is a publication from 2018. It examined the state of Black mental health care.

Some psychiatrists were interviewed for a chapter of this book where they agreed that they would like to see Black psychiatrists coming together to create institutional change in the field. They made notable progress, but a lot of the changes made in the 70s no longer exist, including some of those research organizations.

It was serendipitous that Dr. Stewart, the first Black president of the APA was elected. I could speak to her about what the BPA meant to her. I highlighted that here.

I finished this project in February of 2020 immediately before the Covid-19 pandemic. That was before there were more discussions where the general public had to reconcile with the inequities in our health system, and the disproportionate toll on Black and Brown communities.

I tried to show that dismantling racism in the field of psychiatry, and in general, is inextricably tied to large scale social change. It happens in stages. The work is yet to be complete.

That's all I have for you today. Thank you so much.

Speaker: Thank you Simone for a wonderful talk. There was a round of applause, but I didn't unmute in time. We may have time from one question from the audience, either in person or virtual.

Hold on.

Speaker: Hi, Simone, thank you so much for an important historical piece of the puzzle. This is Anthony Hatch. I spoke earlier. My question is about the training of Black psychiatrists. Where did they go to medical school? What were psychiatric training facilities like at HBCU like Howard and a few other elite institutions that would let Negros in?

Simone Dreux: I didn't get to delve into that project fully. I wanted to make that a spinoff of this project. I found that a lot of these were trained in HBCUs. Some of them were a bit more spread out. I know Dr. Pierce went to Harvard for medical school.

It's not necessarily that everyone went to the same schools. I think their experiences changed over the course of the time periods that I was talking about. Even before the 60s, it's hard to know what their experiences were like. I was able to track what Dr. Ernest Williams was saying about his experience training at Howard. He said color played a huge role in who could become a physician in the first place.

Another doctor mentioned people not wanting to meet with him at all.

I was only able to access the voices of those who were more vocal and able to get through psychology training. I don't think there's as much being said on the before piece. I know there's one anecdote from my research. A psychiatrist was talking about his experience at this psychiatry conference. He said one of his white colleagues explicitly said they didn't think Black people were fit to become psychiatrists.

I've heard snippets about the training, where they were, etc. I don't have a complete piece of that story. I think the training is another area that is worth researching. There's not that much that I've found in this historical area.

I'm sorry I don't have a more thorough answer to your question. I think it's something that I also wondered.

Speaker: If you can please give another round of applause for Simone's wonderful presentation?

[Applause]

Simone Dreux: Thank you. It was wonderful to be here.

Speaker: We have another presentation Psychiatry's Carceral Imaginaries: Lessons from Science and Technology Studies (with Andy Wen and Taiwo Alonge). As a heads up we may run 5 or 10 minutes over our finish. Please give a warm welcome to the both of them.

Andy Wen: Hi, everybody. Just pulling up our slides. Everybody see that okay? Is it showing as a slide?

Taiwo Alonge: I think we're good there.

Andy Wen: We're on now. Thanks for being patient with that. Our title is Psychiatry's Carceral Imaginaries: Lessons from Science and Technology Studies (with Andy Wen and Taiwo Alonge). We won't take too much time because we want to talk at the end.

We will talk about positionality modeled at AZA [sp?]. Thank you for modeling this. I will start. My name is Andy Wen with he/him pronouns. I am of Chinese heritage. Your family is part of the Weh Minority and on my mother’s side white American from Washington State.

I grew up in Duwamish occupied territories known as Seattle. I am now a resident at Yale. Yeah, turn it over to Taiwo.

Taiwo Alonge: What's up, my name is Taiwo Alonge. I am a Nigerian American descended of Yoruba. I am a second year resident at Yale with Andy.

Andy Wen: A quick overview of our talk today. We are going to talk about why STS and why we are looking at insights here. Just some definitions to get shared language. Going to our primary paper going over how we're framing the approach to what we do every day.

It’s Ruha Benjamin's definition of carceral imaginaries and work as STS and work on identifying technologies. Then we will return to Benjamin's paper on abolitionist ideas and get some good discussion going hopefully.

Starting with definitions. STS is also called "Why Science and Technology Studies?" We don't interface with the Humanities as much as I think we should. I have a huge crush on people who do this type of work. It is exciting to see a magnifying lens up against what we do as physicians and psychiatrists.

One lens is a tool, infrastructures, policy, or documents that is part of the way we go about our business. We can think about these objects in a little bit more detail and be intentional in how and why we use them. The big part is making the invisible visible.

And then we throw the word "carceral" around a lot but the big thing for me is it is the antonym of liberatory. Anything from objective prisons and the infrastructure of containing humans to surveillance state stuff or anything that is anti-liberatory.

Then his paper talks about Critical Race Theory, the hot topic in the last decade or so. There are several tenants. Without going too much into it is ordinary of racism. Racism is present in all these aspects of society. In Degado's book on race theory they use the word "normal science" in the ordinariness of science.

Also, one of ours touches on neoliberalism. It is a philosophy that shifts economy model of privatization. It is sort of defunding public health and education to maximize profits for individuals.

Finally, abolitionist Consciousness is an abolition and building of liberatory ways of being.

I am not sure if you want to add to this page?

Taiwo Alonge: Not much. Thinking of neoliberalism and psychiatry and how in a lot of ways our work extends carcerally. It goes to neoliberalism because our work is driven by the economies and thinking of abolitionist conscientiousness and what we want to do for our patients and how we might not fill particularly minority individuals.

Andy Wen: Our first paper frames our talk. It is called Catching Our Breath: Critical Race STS and the Carceral Imagination by Ruha Benjamin. It is written not as a series of case examples of how these intertwine but calling on STS to take critical race theory and people’s attention to how technology exhibits carceral logics.

Again, I mentioned critical race theory, mentioning racism as normal. In normal science how do we denormalize or thinking about how racism is so normalized in our everyday practices and making what is often invisible and practicing the science more visible.

Another thing Benjamin brings up is a whole book on race as a technology. It creates parallel universes. There are examples she provides of how race as technologies that reify race. For example, things that require upgraded. Violent voter intimidation becomes unlawful laws [and more escalations].

These are the guiding questions that Benjamin places in her paper that I think are poignant questions. This is also for us to think about when we move forward in psychiatry and people who do science and buy science. She says that in moving forward several features of carceral imaginaries are important for research.

[Reading quote: . . . this is not only looking at what is tied to police and prisons but understanding scholarly of techno-scientific development. Who is put in place, aroused, or coerced to create innovation?]

She also says,

[Reading quote: . . . it would benefit from how carceral visionaries collect ideas of the future.]

I will let that sit for a second.

With those questions in mind, we started our literature dissertation with papers that fit in these frameworks and psychiatry.

I know you wanted to build off of this a little bit.

Taiwo Alonge: I build up a little towards the end when we discuss the papers.

Andy Wen: Okay. Now we have [title on screen]. Our first paper, “Neurobiologically Poor? Brain phenotypes, Inequilaterally and Biosocial Determinism.” This refers to Benjamin's paper [author is Victoria Pitts-Taylor].

She looks at 21 studies of neuroscience of poverty, neuroplasticity, and proposed interventions for poverty's impact on the brain. She said these papers share neurocentric logic prioritizing brain-based explanations for human behavior.

Also, she says papers rely on correlational evidence and exhibit biosocial determinism. They looked at children and poverty's effects on the brain but didn't put it in a performance matrix to see whether the changes in brain wave activity were consequences of ableist definitions of working neurocircuitry, I guess.

That's one example.

For the topic of biosocial determinism, there was the idea that biology causes social problems while admitting that social problems impact people's biology. That's an example of fixing people into place, fixing them as impoverished, or fixing poverty in the brain.

She also notes this research is largely colorblind. There's no talk about the racialization of poverty while they use racialization in their poverty. They use phrases like "the other side of the tracks," "the inner city," etc.

Technoscience interventions converge. The result is the result is creating drugs to address the problem, create certain therapies that reduce the impact of poverty on the brain instead of a social attempt at addressing poverty itself.

Taiwo Alonge: Our next paper is [reading title at top]

In this paper, our objects and technology are articles, editorials, etc. on personality disorders, policy documents, etc. Our main focus is diagnosis and policy.

We are looking at how policy makers are aligned. The note is that personality disorders prior to 1983 were deemed untreatable. These are people that clinicians felt were burdensome from the system. They are not able to be treated by psychiatric means.

With the installment of this act in 1983, there is a shift that occurs in policy and clinical practice. For someone to be involuntarily hospitalized, treatment needs to be justified. Before this, people would be put in caracal institutions or involuntary hospitalized. It changed the frame through which we interact with people who have personality disorders.

When this act was passed, there was a lot of movement and activism from clinicians to destigmatize personality disorders so they could treat and get people treated. The people who are fixed are those diagnosed with psychopathology. With the changing of this law, it is difficult for people to be brought into mental institutions. Therefore, work is done to catch up clinical practice so they can capture these individuals.

Over time, they saw this occur. In 1980, with the DSM-3 dropped in the United States, people in Britain liked the nuance delivered to personality disorders. It was the first time a major section in the DSM-3 was attributed to personality disorders. More vagueness was removed.

We saw treatment modalities being used. Something to note is that there were not a lot of new treatments used. There were a lot of existing therapeutic interventions along with pharmaceutical interventions. The people fixed were those caught in society. They changed the diagnostic classification of fixed and plastic.

The idea is that personality is changed to something that is treatable. There is a stigma but there is treatment which leads to people being put in these systems. The techno scientific development lets them corral people.

A person was released and killed people. This led to more clinical diagnoses. There was an act passed in 2006 that changed the treatability to "appropriate treatment." Now people can be treated based on whether appropriate treatment being available instead of a disease being treated.

Next, we have an article that doesn't specifically talk about race. I'm not as familiar with the UK literature. The United States presentation given by Simone talked about the DSM criteria to think about paranoia and how that led to the stigmatizing and pathologizing of Black people. You could probably extrapolate that to the UK and the identities facing these systems.

Andy Wen: Our next paper is called [reading title at top of slide]

It was an early paper in 2005. This is one of the papers that has one of the most clear cut examples of technology. She analyzes the treatment and development of two different kinds of drug testing technology, sweat patches and hair analysis. She calls this "suspect technologies."

She brings these up as examples of things that are led to reinforce exclusion and incarceration, revoke participatory citizenship, and define who qualifies for social services. The impetus in the development of these technologies is to assess risk and define a new era of security through evaluating who fits in this bucket of people who are risky.

Notably, the development of these technologies really relied on carceral systems. They were first tested on people who were on probation. What was important for the companies developing these tests was to get judicial acceptance of drug test results as admissible evidence. If they could do this, they could widely distribute these as viable means of fixing people as positive or negative on their tests. Then they could have judicial responses to the results of the test.

You see it is not directly named in this paper, but the neoliberal impetus of creating a technology, marketing it, and then having the incentive for it to be well utilized, and the paper talks about how they didn't just push this in caracal systems. They try to go into HR departments and hiring departments in order to say that they can use this as a more reliable way than urine testing which is at risk for tempering. They marketed the benefits of sweat patches and hair analysis.

The main takeaway from this is that the technologies we use have already leveraged those in captivity for their development. This reproduces further incarceration and social stratification. These technologies take a role in subject formation. This creates people who are positive for a test. Then it leads to their subjugation where they are forced into incarceration, have their children removed, don't quality for social services, etc.

A final takeaway that Nancy Campbell advocated for was to apply the strict scrutiny policy for the development of technologies. With social sciences, by the time a technology is investigated by a sociologist or STS scholar, there are all of these case studies about how a significant amount of harm has been done retrospectively.

In thinking about strict scrutiny, it's a legal term. Is this law going to negatively impact the people it is intended to govern? There's an advocacy from Nancy Campbell that we need to apply this at the beginning of technoscientific development, before people experience anything as harmful to them.

Taiwo Alonge: The last paper is [reading title at the top of slide].

In this study, [reading bullet point 1].

This is the case of two women, sisters, Jamie and Gladys who were arrested and given dual life sentences for a robbery that amounted to $11. There were six men involved in this. During this time, Jamie gets really sick and ended up with end stage renal disease. She required a kidney transplant. Her sister was willing to donate a kidney to take care of her.

In this context, the medical and clinical tools are not available in prison. They were requesting a pardoning of their sentences so she could receive this life saving care. A lot of advocacy went around this. Jamie's life sentence went from lifetime to a death sentence due to the mismanagement of her health.

The governor, Haley Barbour, suspended the life sentences. Biopolitical citizenship was created for both of these people. If Jamie gives up her kidney, she has one less kidney. That creates disability. Gladys has a new kidney and is immunosuppressed and has to be on immunosuppressants indefinitely.

They were fixed as criminals forever. Their felonies were not pardoned. Their full citizenship was denied. They are not able to vote or hold jobs. They are required to pay $52 for the administration of parole. They are Black women, and they look at how they are fixed.

Gladys has a quote from her grandmother that says, "slavery is not dead in the south, it's called law now." Slavery has been updated through Jim Crow to mass incarceration. Jamie and Gladys' case speak to that. With the suspension of the case, you see how the state responds to Black women and Black people in general. The suspension of the case by the governor was based on Jamie's care becoming too expensive for the state.

Getting dialysis as needed would require $200,000 a year. Because of this, it benefited the state to have her sentence suspended. That way they don't have to pay for this. The other note was that the sisters would be moving to Florida. That would take the cost of their medical care, since they were using Medicaid, out of the state.

Black bodies are again subject to the state and seen as pieces of labor as well as an item of expenses. When keeping them captive became too expensive, that's when their sentence was able to be suspended.

[Reading final bullet point]

Then, we're returning to Benjamin. Benjamin asked us two things to keep in mind. [Reading paragraph 1 on screen, paragraph 2 on screen]

As I relate to psychiatry, there are a lot of technologies we engage with every day, whether our diagnostic tools, ability to involuntarily admit people, our ability to give people medications over objections to through legal means or restraint, we can think about with institutional practices we think in our daily clinical scope that continue to oppress people outside of prison.

Thinking about our abolitionist conscience involves thinking about these systems and how to dismantle them.

I want to leave you with some space to think about that as it relates to the things we have discussed, or these carceral logics inside psychiatry in general along with the technologies.

Speaker: Let us give a warm round of applause for Andy and Taiwo.

[Applause]

We can take a few questions from in person and online.

Andy Wen: Is it possible to see all the participants and panelists either in person or online? There are some faces we would love to see.

Speaker: Unfortunately, we're not setup to do that.

We have one in person question. Give me a moment. The people online will be able to hear you. No worries.

Speaker: Hi. Sorry you can't see me. [Laughs]

Thank you so much for this compelling overview of important STS work. My name is Rosa, and I am at the nursing school. In a previous life I studied STS under Victoria. Shout out! She's awesome, she's great!

Now I am in nursing and healthcare. I have struggling with integrating what I learned in STS and applying it as a healthcare professional now especially in our complicated landscape that is our healthcare system. I am curious how you guys who have studied STS are navigating it in your practices. Thanks.

Andy Wen: I mean when I first kind of talked about this, some of this talk was based off of conversations that I had in a science technology seminar. One of the people in the seminar asked me why I was even looking at this stuff, like what it would do for me as a practicing psychiatrist.

In the practice of making the invisible visible. I think about that a lot. I think about what we can brainstorm as our treatment modalities, one, of how treatment modalities are developed and how we can talk about them with our colleagues. Are our antidepressants, how are they exhibiting neoliberal logic?

How do we incorporate these modalities in caring for our patients, so we don't just prescribe a pill and rack up money. That is one way I am conceptualizing this. In advocacy talking to our colleagues about how they are doing their science or carceral logics and what they focus their attentions on in their research is something I think about.

Taiwo Alonge: Briefly, STS is relatively new to me. Shout out to Andy for putting me on game. These principles I have thought about for a really long time. Again, making the invisible visible. Thinking about how our practice and how we think about and organize and how we treat people and what that treatment means instead of the bitter question of why they present the way they do, the individual person.

How to do that within our scope of practice is pretty difficult because our scope is structured. In the Benjamin paper she says you can be racially tolerant but if you clock in and out the machine does what it does. It is thinking how to work outside the machine whether that is advocacy or material needs people need and how to get it to them.

And using our position as respected people in society to try to bring resources to people who might not have them.

Host: With that I think we're going to conclude the session. If we could give one more round of applause.

[Applause]

Thank you everyone for joining. We're going to have a break 'til 5pm, so the next 9 minutes or so, where we will have some closing remarks. So, stay tuned. Thank you everyone.

[End of Parallels 3A]

[Closing session]

Speaker: Hello everyone! We are ready to get our closing remarks started.

Thank you all for your patience today, both online and in person. We're excited that you, and your participation made RebPsych hybrid a success. We want to recognize the hard work of the organizing committee who made this possible. [Listing members]

There are also our faculty advisors.

A special thank you to our remarkable presenters who shared their talents and creativity across the country. A special thank you to the community organizers who challenge modes of care and imagine peer led non-carceral forms of care.

Speaker: Hello everyone, it has been incredible to hear all the presenters today. This work is so important. I want to bring it back to history. Europe's campaign of colonization was not about the seizure of land and killing of people. It was the seizure and erasure of knowledge. It includes the erasure of our own lives, and precolonial ways of connecting.

One of these operating environments that were created was Euro-American psychiatry. The work we are trying to do at RebPsych is exposing and dismantling these technologies in our minds and bodies.

Many presentations today, along that vein, are about rebellion and riot. They are people standing up to the police, prison state, cages of our own colonized psyches, etc. Some of our preventers are working to pry the fingers of the surveillance state out of medicine so it cannot be weaponized. Otherwise, they are liberating substance use treatment and bringing it into the communities. We hope you are resolute and angry. This conference is a call to action as much as it is about knowledge.

Speaker: I wanted to reiterate the thanks to everyone. There was a literal fire alarm in this room. We still persevered. Was it sabotage? I don't know.

Thank you for being patient today. Building on what was being said, I think it's important to acknowledge the caracal systems that are built into psychology that we were talking about today and that were featured in Professor Hatch's keynote. They're not out there somewhere to be fought against. They're here, propagated in this institution.

There are many examples. One is in the Connecticut mental health center. They are discussing and will likely implement TSA style scanners and metal detectors that community members will have to walk through to get help. This is being implemented in an area that needs state based insurance. If you go to Yale University, who tends to serve people with private insurance, you are not forced to undergo these surveillance technologies. This is relevant for where we are sitting today. I think it's important to keep in mind.

To build on this conference being used as a call to action, I want to lift up a few calls to action. One was from the New York Lawyers for Public Interest. They're doing great work the intersection of detention and using medicine to get people out of untenable detention sites. There will be a follow up email and we will plug these interventions into the email if you want to follow up and engage with these organization's work.

I want to pass on a phrase, "be anarchical doctors." I will hold that with me.

[people laughing]

Speaker: Project LETS encouraged us to examine where our history comes from and the implication of harm in the knowledge we use as clinicians and practitioners.

Across a variety of panels, there were pushes for peer respite oriented programs as opposed to these dated carceral systems.

Speaker: I want to add one more call to action. It's for Justice LA. It helps to fight the carceral system taking over LA County. There is a follow up number you can text. 213-463-6287. Text Help Justice to that number to get involved in their efforts.

Thank you all, again, for coming. I hope this is the beginning of the conversation and not the end of one. We will be emailing presenters and attendees for these calls to action. We would love to hear how this went for you as part of the people who attended or presented. You can always reach us at RebPsych@yale.edu.

We would love more people, especially at other institutions, to get involved. If you would like to get involved in the organizing of this, please reach out at that email address. As I said, we will reach out to you. Thank you everyone for coming. We really appreciate it.

[Applause]

[End of closing r