

**Stories of Madness: Exploring Resistance, Conformity, Resiliency,  
Agency, and Disengagement in Mental Health Narratives**

by

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## DEDICATION

To my Lord and Savior, Jesus Christ.

*The man from whom the demons had gone out begged to go with him, but Jesus sent him away, saying, "Return home and tell how much God has done for you." So the man went away and told all over town how much Jesus had done for him. (Luke 8: 38-39)*

## ABSTRACT

Old and present mental health systems tend to emphasize mental health service users as passive recipients of psychiatric care, which suppresses the idea that people who experience serious mental illness are able to comprehend their own sickness and recovery and therefore engage psychiatric experts about their care. This dissertation seriously interrogates the ways in which those who experience serious mental illness become agential, resist some of the control mechanisms, relationships of power, and infantilizing rituals found within the Canadian mental health system, and survive abject circumstances. Drawing on my own autoethnographic experiences with psychosis and psychiatric hospitalization, as well as 10 interviews with mental health service users, I argue that narrative approaches to inquiry and a post-anarchist praxis can reveal and liberate our agential capacities to recover and live through madness that otherwise become less known through biomedical approaches to mental health research. I identify some of the porous boundaries between the livable and unlivable forms of madness, and explore the complex relationships between service users and their caregivers whose penultimate goal is to help us live a manageable life. I conclude by discussing the contributions of this dissertation and reflect on some of the practical needs of the current mental health system.

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## **ACCOMPANYING MATERIALS**

Johnston, M.S. (2013). *Dragon in the Woods (Shaped by Sea)*. Rock Album, 23 Tracks.

Johnston, M.S. (2017). *Out of My Mind and Back in Again*. Rock Album, 11 Tracks.

## CHAPTER 1: INTRODUCTION

### *Preface*

It's 2014, about a year into my recovery from a battle with psychosis and resignation from a PhD program on the west coast of Canada. I wipe the tears from the innards of my eyes before they burst and tremble. This is a daily ritual. I choke back the emptiness and confusion that spills out the creaks of my mind while the numbing antipsychotics I ingest restrain me. A bucket of water has been thrown onto my brain. It is icy, and no longer on fire. But I am cold inside. Broken, useless, unimaginative, and traumatized, I endlessly question how I should proceed with a life I think is irreversibly ruined. With the little energy I have, I hold on to what is left of my family following my self-destruction. I speak every day to the God I met in the pits of madness. It is just enough to convince myself I am still worth something.

The days go by slowly, the heavens are still. And I watch them: I stare into the sky and wonder; how can I transform all that I feel into knowledge? Beaten, angry, and reduced to breaths and sounds, I wonder how I can still make a difference in this unkind world.

To pass the boredom and get away from the many medicated thoughts that occupy my mental space, I decide one day to visit the Dalhousie University Library in Halifax, Canada, where my wife was completing her master's degree while I regained my sanity. Rummaging through the critical literature on mental health studies, I find Seth Farber's (1993) book, *Madness, Heresy, and the Rumor of Angels: The Revolt Against the Mental Health System*. It lays out a damning critique against the psychiatric establishment, which I had seen rehearsed in many other works by other mental health professionals (Holmes et al. 2014; Szasz 1994, 2003). But what strikes me as most awe-inspiring is not how Farber depicts the stories of

mental health service users in (more or less) an unadulterated form. My interest lies, rather, in how their experiences do not always come across as pathological and dysfunctional. Finding light in this hell, the service users see some of their struggles with madness as enlightening, instead of destructive. I also recognize how they recovered from mental illness through their own resiliency and agency, in conjunction with the collective efforts of their family members and healthcare professionals.

I then realize that if others could story their pain in a way that showcases their capacity to survive abject circumstances, remain resilient, recover and learn, and then help others do the same—so can I. I reach inside myself and decide that night I am on a mission to look for ways that my own pain might help me take back all that I had lost. I decide to start a PhD all over again at Carleton University in 2015. Bewildered by the power of the story, and trying to make sense of my own mental health experience, I am left with many questions I want answers to:

- 1) What place do mad people have in society to resist those who conceive of madness as an ontology or space that must always be fixed and exited?
- 2) How do we still acknowledge the ‘badness of madness’ as a source of both ruin and enlightenment, and something we must recover from and move past in order to live a manageable and viable life?
- 3) Who is accountable to mental health service users when they identify mistakes in the mental health system? How do we identify the unstable boundaries between the livable and unlivable forms of madness? In the face of that knowledge, what are the best ways to respond?

4) How do service users respond themselves? What kinds of agency are they afforded?

How do they navigate and resist the mental health system?

In trying to uncover more about this mystery, and to better understand how stories can reshape lives and tell us things we do not yet know, I embark on this dissertation.

### *Research Context*

This dissertation is most concerned with old and present mental health systems' emphasis on service users as passive recipients of psychiatric care. This unfortunate reality suppresses the idea that people who experience serious mental illness are able to comprehend their own sickness and recovery and therefore engage psychiatric experts about their care (Cohen, 2008; Kirmayer, 2000; LeFrançois et al., 2013). Those experiencing mental illness are often "excluded from the discursive practices, disciplinary hegemony or dominant regimes of truth within the mental health system" (Joseph, 2014, p. 273), which creates a psychiatric model that is enduring criticism. The suppression of the voices of mad people only work to strengthen institutions where acts of violence, humiliation, and coercive authority inevitably prevail over compassionate healthcare discourses. Alongside this detriment, such discourses restrict analyses from conceptualizing the varying forms of agency, responsibility, autonomy, and self-determination that service users engage. Hence this dissertation will reveal, situate, and mobilize such voices.

Few studies are written from the perspective of the psychiatric inpatient (see Kanerva et al. 2013) with particular focus on the material circumstances that enhance (i.e., safe and interactive environment, staff sensitivity, experience, availability, teamwork and leadership) or hinder (i.e., intimidation, medical errors, unsafe practices) patient safety and well-being (Baker et al., 2006; Borckardt et al., 2007; Johnstone, 2007; Lamontagne, 2010; Mahoney et

al., 2012). Patient safety is generally defined as liberty from accidental or preventable injuries produced by medical care (Zaugg & Wangler, 2009) and exposure to practices that reduce the risk of adverse events (Ilan & Fowler, 2005). Studies have found that patients feel that their dignity and safety is respected when caregivers listen to their stories and needs and give them autonomy over their treatment decision-making (Chambers et al., 2015; Kuivalainen et al., 2017; Lindwall et al., 2012; Quirk, 2012), and powerless in settings where caregivers or security personnel misuse or abuse their power (Burstow, 2016; Holmes et al., 2012; Jacob & Holmes, 2011; Johnston & Kilty, 2014, 2015, 2016; Johnston, 2014; Johnston & Johnston, 2018; Mason, 2006; Szasz, 2010a).

While mental health systems have still come a long way since the days of ‘insane asylums’ and their history of cruelty and rampant abuse of people under their ‘care’, they are still plagued with controversial issues of power and control. Despite calls to eliminate or reduce patient restraint and seclusion practices (Ashcraft & Anthony, 2008; Barton et al., 2009; Cleary et al., 2010; Federman, 2012; Lake et al., 2010; Huckshorn, 2004), Muir-Cochrane and Gerace (2014) found that their controversial usage in many areas of the globe—including Canada (Dumais et al., 2011)—has increased or stayed the same in forensic settings, emergency departments, ambulances, and general hospital wards. Indeed, legitimate fear of patients is a major variable influencing nurses and doctors’ decisions to distance themselves from care, and manage healthcare space in terms of risk and security (Jacob & Holmes, 2011). On the other hand, some service users are grateful to doctors for their treatment, even if they use some measures of force, power, or coercion (Katsakou, 2012).

Alongside people’s positive and negative experiences with doctors in the mental health system, it remains imperative to question our assumptions concerning the

legitimization of mad discourses, psychiatric treatment, and who gets to advance and implement such knowledge. Mental health and mental illness intersect with many philosophical concerns and concepts, such as agency, responsibility, rationality, self-identity, and self-determination (Rashed, 2019). For this reason, critical work on the treatment and care of mental health service users raises concerns pertaining to bioethics.

Much of this work accepts, or makes peace with, the diagnostics categories and methodological presuppositions of models employed by medicine, where those with mental disorder are construed as blameless victims of misfortune, indistinguishable from people disabled by other forms of ill health...Irreconcilably contrary, meanwhile, were the antipsychiatry claims of Szasz, Laing, Foucault, and the feminists. Mental illness was not an illness at all; medical psychiatry was an organized, predatory force, to be resisted. (Radden, 2019, p. ix)

So there seems to be two sides of the coin concerning work on mental health service users: we either accept biomedical approaches to understanding madness and the inevitable control techniques and forms of institutionalization that become thought of as necessary to manage the population, or we can think more critically about the institution of psychiatry and thus open up new conditions of possibility upon which to view mad people. For critics of the psychiatric apparatus, what is it about psychiatry that needs to be resisted? Foucault (2006), who himself was subject to psychological supervision and treatment, intensely characterizes the psychiatrist as someone who

...makes reality unreal in order to act on the erroneous judgment maintained by the patient...[and] will no longer be the individual who considers what the mad person says from the standpoint of truth...The psychiatrist is someone who...must ensure that reality has the supplement of power necessary for it to impose itself on madness and, conversely, he is someone who must remove from madness its power to avoid reality. (pp. 131-132)

What Foucault and other critics of psychiatry are getting at is that psychiatry creates the truths of the mind, and that in doing so, displaces madness from its potential to be seen as transcending the mundane and realist dimensions of life. Madness for Foucault is about the

power of classification to structure the physical world. What Foucault (1988) calls the great confinement is in part important because it removes sections of the population (mad people) from the visible world, confines them, enables doctors to detect regularities in their behaviour and dissociate this behaviour from the normal population. The very figure of the rational individual is based on the constitutive exclusion of mad people. Truth is power, and so the psychiatrist emerges in this new landscape and therefore takes forms of reality (the lived experiences of mad people) and serves to reinforce the exclusion. To Foucault, the psychiatrist's function is to ensure the structure of state-reality and prevent alternate models. Necessary or not, in Foucault's eyes, this is an act of power, and a powerful one at that because psychiatry's grip on what is a stable mind is so strong that patients become framed as people who are in need of discipline and treatment. This epistemological model of medical truth is sustained through complex processes of information, discourses, and value systems distributed by psychiatry – communities of experts who enforce scientific and social realities on mad people in order to create a category of difference (Hacking, 1986).

Historically, by defining mad people as a class of people with definite properties, and exploring these properties through systems of reason and rationality, mad people (and their voices) became easier to control, contain, and moderate (Funnell et al., 2018). Psychiatric power began as a moralizing construct to alienate citizens; “a regime of isolation, regularity, the use of time, a system of measured deprivations, and the obligation to work” (Foucault, 2006, p. 173), and one that eventually became highly profitable in asylum and prison systems where many agents are employed and connected to strong pharmaceutical industries (Whitaker & Cosgrove, 2015). Psychiatric power is exercised through intense documentation and procedures of continuous control, whereby attending psychiatrists and physicians treat

each individual patient as a ‘case’ in order to “gain hold over the body and normalize behaviour” (Funnell et al., 2018, p. 3). This power has always gained strength through legislative authority across the globe, as those who threaten moral order and pose a potential physical threat to ‘normal’ citizens can be confined indefinitely in accordance with judicial discourse (Rose, 1990)

Of course, to invoke a cliché, where there is power, there is resistance. Following the critical/antipsychiatry movement (which I critique in Chapter 3), a new movement of Mad Activism emerged, where madness is conceptualized as a non-pathological identity with its own distinctive culture from which to draw inspiration, meaning, as well as political and interpersonal strength. Still controversial, this claim goes further than service users requesting less stigmatizing language about mental health, participation in policy-making decisions, and calls for justice over poor treatment in the mental health system (Radden, 2019). Rather, contemporary Mad Activism calls for authority over the experiential landscape of madness, and the right to be considered with integrity among social norms, discourses, and understandings of mental health and illness (LeFrançois et al., 2013, 2016). Some psychiatrists even agree that those who reject the medical framing of their problems need to be recognized as legitimate stakeholders, and that the decisions to intervene with the mentally ill should happen in consultation with other interested parties (Bracken, 2012).

Positioned within the larger field of critical disability studies, Mad Studies scholars and activists are also reevaluating the consequences of what it means to participate in, or be dominated by, regimes of psychiatric power. More than a critique of the medical model, a denial of the reality of madness, or revolt towards the power of psychiatrics, Mad Activism calls for changes in governance and self-determination – the power to determine our

identities, treatments, or levels of disengagement (Rose, 2006a), and to be thought of as ‘experts by experience’ (Voronka, 2017). These identity politics steer research to consider lived expertise equally, instead of “positioning patients/users/survivors as outsiders, objects for interpretation and research ‘on’ rather than ‘with’” (McWade et al., 2015, p. 305).

This dissertation is situated at the porous borders of Mad Studies, narrative inquiry, and post-structuralist interrogations of medical power, complicity, and agency. I explore how I and ten mental health service users navigated the mental health system. Our journeys and mental health identities diverge, conflict, and intersect. Amidst the messiness of our stories, I analyze our agential capacities to take life into our own hands, during both the darkest moments and epiphanies of madness. I examine relationality with the myriad actors within the psy complex by exploring how mad bodies interact, comply, and resist medical professionals who exert varying degrees of control, power, and incompetence. I consider also how medical professionals, amidst their complicated, cultural, and exhausting relations with the psychiatric establishment, display genuine efforts to save lives and help bring us back to the reality operating on more lucid terrains. Our narratives demonstrate our capacity to breathe meaning into madness, to critically reflect on the workings of the contemporary mental health system, and escape discourses that render us as unimaginative, always/already unstable, and out of control of our destiny.

### *Note on Language*

I have not avoided using the terms “mentally ill” or “patient” in this dissertation, although like Boschma (2007) and Landry (2017), I am aware of the socially and culturally constructed use of the terms. Using these terms implies knowledge that there is always cooperation between a person and their caregiver, when in reality we cannot assume that each

person who experiences mental pain or distress accepts that they are ill, or wishes to be treated in accordance with the established psychiatric diagnoses, treatments, and discourses available. These terms can also be taken as pathologizing by service users; particularly, those who do not feel like biomedically reductive terms capture the essence of their experiences. Assuming that mental illnesses are, or could be, *in part*, ‘diseases’ and ‘chemical imbalances’ is controversial because it may imply that these are valid understandings and categories for all people. That is not my intention, of course. I say ill, because I am a mentally ill person who, as part of the Mad movement, accepts that “ill” necessarily emphasizes and acknowledges the need for medical treatment in some cases. Many of the participants you will read about in this dissertation identify as mentally ill, and rather than feel stigmatized about it, they believe that in some cases mental health labels can be liberating. If this is not the case for the reader, please do not take offence, but understand that I am trying to engage a praxis of mad studies that is open to all possible understandings of madness, including those imposed on us by caregivers or ‘experts’. And I say this with an understanding that there is little agreement in the literature that extreme distress is accompanied by chemical imbalances (Moncrieff, 2008). With tension remaining, I tend to refer to mad people as “mental health service users” because it is a generic and less controversial description of the people who use mental health services. I avoid the terms like “mental health sufferer” because it may imply passivity and victim status. While I tend to use “service user”, psychiatric survivor is an applicable term to some participants in this dissertation who assert that some forms of psychiatric treatment can be considered abusive (see Mental Health Foundation, 2019).

Further, I use the terms ‘psychiatric apparatus’ and ‘psy-complex’ to make it clear to readers that my critique extends to the related disciplines and governing institutions that, in

some way, tend to draw on, reinforce, or enforce the ideas and practices of psychiatry (i.e., psychology, social work, nursing, counselling, care, and so on). That is not to say that everyone who is employed by, or benefits from, these professions endorse psychiatric knowledge, but I recognize that psychiatric power strikes us in the most basic areas of our life, wellness, family, education, and social governance. Hence, I intend that my ideas speak to (rather than ‘Other’) a wide range of interdisciplinary audiences, with the hope that they will become more involved in the global struggles and resistances of mental health service users.

Before I uncover some of the meanings of madness, I will now take readers through a summary of each chapter.

### *Chapter Summaries*

Chapter 2 overviews some of the historical and contemporary discourses and practices of the psychiatric apparatus. I explore how mad people were suppressed and confined in accordance with modern structures of governmentality. I interrogate how psychiatric power normalized under widespread systems of social control — systems that although have changed with deinstitutionalization and modern practices of care, still operate under the directions, powers, and influences of the biomedical model. This framing of medical power is not without its tensions of course, and I seriously consider the trust and agency of service users to produce knowledge that nuances expert discourses. I take up mad scholarship and narrative forms of inquiry in mental health which try to shift power and expertise onto service users, and consider some of the limitations of this approach.

Chapter 3 mobilizes a post-anarchist perspective to assist me in analyzing the narratives of service users. Post-anarchism takes anarchy as an ontological principle that

must be adopted in any analysis of institutions of power. In this respect it is a continuation of Foucault's understanding of power as an inherently unstable relation, always susceptible to dispute, contestation, and reversal. As Newman (2016) writes, post-anarchism is "a form of autonomous action, a way of acting and thinking anarchistically in the here and now" (p. 12). Simply, post-anarchism takes a view of politics in which essential identities are de-privileged as the point of political contestation, and one where normative categories are destabilized. I argue that anarchy is not seen as a desired Utopian end state based on the rejection of hierarchical authority and the valorization of a more fundamental level of human existence. I also conceptualize the concepts of autonomy, responsibility, resistance, and agency, which become instrumental to understanding our narratives.

Chapter 4 fleshes out the narrative research design of this dissertation. I engage the epistemological turns that shape how narratives are taken up in sociology and mental health studies, and find myself located at the post-structuralist intervention that explores the blurred, messy, political, intersectional, autobiographical, and discursive ways of knowing and engaging social forces. I then discuss how this framework of inquiry influenced my approach to interviewing and doing autoethnography. I end the chapter with some dialogue on the many ethical considerations and tensions this dissertation was confronted by; specifically, the challenges of triggering, emotionality, and risk in talking with participants about serious mental illness, as well as the burden the research placed on myself by reliving trauma.

Chapter 5 reveals, in visceral depth, my mental health story. I take readers through a poetic and artistic representation of what it was like to be a psychotic body, in desperate need of help. I discuss some of the spiritual enlightenments I encountered, such as an experience with a deity, and I critically analyze my agential capacities during absolute mental illness and

chaos. I reflect on the role my family and healthcare professionals played in my recovery, and I use these insights to help reflexively engage the analytical chapters that follow.

Chapter 6 uncovers the narratives of two men who experienced heavy psychotic symptoms. Their narratives demonstrate the agency of service users experiencing serious mental illness to survive, reflect on the epiphanies their circumstances created, as well as navigate very complex, surreal, and sometimes incompetent encounters with mental health professionals. We also are provided with insights into how service users resist the psychiatric apparatus through techniques of passivity and disengagement, and learn how these strategies empower them and strengthen their resiliency.

Chapter 7 seriously interrogates the role family plays in shaping how mental illness and health is experienced and framed by service users. We are presented with three narratives of people who experienced extreme pressure to succeed academically by their parents, and had to draw on the psy complex to get through school life, build their identities, and heal their intense mental anguish. They all express varying degrees of frustration and gratitude with the parents, doctors, psychiatrists, and counsellors they encountered on their journeys, and I analyze how mental health labelling and intervention contoured their recoveries and grip on life.

Chapter 8 teaches us about the mysteries of socialization and childhood suffering and how these experiences interact with mental illness in adolescence and early adulthood. Some of the stories showcase the power of imagination, that is to say, how artistic or community endeavours can help service users overcome illness, help others recover, and build new identities. Other narratives in this chapter offer a more direct critique of psy professionals' authority. Some participants question the knowledge of psychiatry and shed light on how

their own personal experiences counter some of the dominant discourses pertaining to Depression, Anxiety, and Post Traumatic Stress Disorder. Another participant, whose experience in the mental health system was generally positive, discusses how professionals taught her to both understand and manage her Eating Disorder. Many of these narratives encourage us to take up questions about the ‘lesser evil’ aspects of treatment in our mental health system that still deny service users autonomy.

Chapter 9 concludes this dissertation by examining its possible theoretical and practical implications; namely, how this case study and representations of subjectification speak to broader social forces and inequalities in the mental health system, as well as the ways in which it is working well. I remark on the benefits of mobilizing a post-anarchist praxis in mad research, review the contribution of this thesis in relation to the main questions posed in Chapter 1, and share my final lessons learned from doing this research.

## CHAPTER 2: HISTORY OF PSYCHIATRIC POWER, DISCOURSES, AND INSTITUTIONALIZATION

*~ A doctor is now present at practically all the important tortures. His role is first of all to say what torture will be the most effective, and secondly, to give medical examinations to make sure that the patient is not a heart case, for example, and in risk of dying. Thirdly, the doctor administers various kinds of injections to revive the patient so that he can physically withstand the tortures and, at the same time, suffer them psychologically in the harshest manner...In these torture sessions not just general doctors serve as technical advisors, but also sometimes psychiatrists, and even psychoanalysts.*

(Foucault [1975]1996, pp. 172-173)

The above passage in Michel Foucault's epigraph comes from a roundtable conducted by Sylvère Lotringer with Foucault, Ronald D. Laing, Howie Harp, and Judy Clark at the 'Schizo-Culture' conference organized at Columbia University in 1975. Describing the militarized response to widespread political protests in Brazil, Foucault notes in this extreme case that the Brazilian military-security apparatus had begun to incorporate psychiatric knowledge when torturing protestors. Seemingly not content to extract a pound of flesh from the bodies of the insouciant, the Brazilian authorities began to attack their minds and souls.

Of course, for those who have studied the genealogy of the psychiatric apparatus, the notion that psychiatric power could be central to state-funded social control efforts is hardly surprising (Breggin, 2006; Castel et al., 1982; Castel, 1991; Foucault, 2006; Goffman, 1961; Gosden, 1997; Smith, 1978; Szasz, 1965, 2003). Neither is it surprising to see this power expressed in a highly coercive manner.<sup>1</sup> While many of the 'tortures' of psychiatry have

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<sup>1</sup> Perhaps for reasons surrounding patient confidentiality and varying provincial/state governance, it is difficult to pinpoint exact statistics concerning how many psychiatric survivors are involuntarily committed to hospitals (and for how long); the percentage of survivors who experience psychiatric violence during their institutionalization (and to what degree); and how complex decisions are made to enforce such outcomes (Røtvold & Wynn, 2016). The Canadian Institute for Health Information (2015) cites that 18 percent of inpatient hospitalizations for children and youth aged 5–24 were for mental health concerns, while the asylum population of the United States shrunk from an estimated 550,000 in the 1950s to 30,000 by the 1990s (Testa & West, 2010). I stress that the length or number of times one is abused during psychiatric detainment does not necessarily speak to the extent to which survivors experience trauma, pain, humiliation, and stigma from these events (Eilers, 1994), or during outpatient treatment (Lien et al. 2015; Link et al., 2008). The first author, who

ceased since the time Foucault was writing, even today, most healthcare agents (orderlies, nurses, security officers, physicians, and psychiatrists, to name a few) can at some point use physical or epistemic violence, degradation, infantilization (or some combination thereof) to control how people under their ‘care’ behave and understand their relationships with those around them (Holmes et al., 2012; Joseph, 2014; Liegghio, 2013). The various individual power techniques include the administration of physical/chemical restraints, medications that shorten life and alter reality, intensive surveillance practices, the use of involuntary incarceration in mental institutions, beatings, infantilizing punishment and reward systems, and various forms of moral judgement and stigma (Ashcraft & Anthony, 2008; Johnston, 2014; Johnston & Kilty, 2014, 2016; Due et al., 2012; Burstow, 2016; Holmes & Murray, 2011; Holmes et al., 2014; Mason, 2006; Meyer et al., 2005). Without these instruments of power or care readily available to them – some of which retain legislative authority in mental health acts (Chandler, 2014; Federman, 2012; McSherry & Weller, 2010; Peay, 2003; Szasz, 1989) – psychiatry would struggle to exist in its current regulatory and professionalized form.

A Foucauldian (2003) reading of medical power suggests that it is generally capillary, productive, never localized, and employed within a web of relations through which subjects manoeuvre (Donetto 2012). Medical power is often shaped by the dominance of biomedicine under colonial interests towards modernization (Zachariah 2014), and closed-mindedness towards alternative medicines (Lakshmi et al., 2015). Despite widespread beliefs in the sanctity of science and medicine, Orlans et al.’s (2017) narratives about medical errors reveal

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participated in restraining psychiatric survivors during his tenure as a security guard in an Ottawa hospital, documented the practices of physical and chemical restraint as being quite common and relied upon by hospital staff (Johnston, 2012, 2014). He was triggered to resign from his position when one woman experienced having her buttocks exposed and being forcibly injected by several healthcare staff as a sexual assault (Johnston & Kilty, 2014).

that doctors, like all other scientific practitioners, commonly makes mistakes or errors in judgment and must learn and reflect on them to improve their practice. So, who gets to call into question or resist the less glorious practices of psychiatry? Who's accountable and what happens when psychiatrists and mental health professionals make mistakes? The exclusion of the voices of the 'mad' from psychiatric discourse and regulation has been central to the success enjoyed by clinical psychiatry since its development in the 15<sup>th</sup> century (Joseph, 2014). This leaves many questions open concerning how people internalize or resist medical conceptualizations of what constitutes a healthy or 'cured' subject.

That being said, while modern day psychiatric power and coercion walks a thin ethical line, some patients actually welcome the various interventions when they find themselves in a state of distress. This is especially true when the coercive measures are non-invasive (sometimes hospitalization, soft room containment, observation in seclusion) as opposed to invasive (mechanical restraints, forced medication administrations) (Krieger et al., 2018). When restraints are used, some caregivers try to build trust back with patients by seeking their advice on how to more humanely and therapeutically interact with them during a crisis (Khatib et al., 2018). It must be said that the decisions to use seclusion, force, and restraint in psychiatric settings are usually made through a complex moral reasoning process that is limited by institutional and professional demands, but can be implemented in a way that some argue still fosters good care (Landeweer et al., 2011). Some caregivers who believe in the use of invasive measures still express discomfort using them and must constantly combat principles of paternalism over respect for the patient's autonomy (Valenti et al., 2015). Sometimes things happen in institutional settings; patient outbursts and violence are difficult to control and know how to best react to it (Liégeois & Eneman, 2008). So again,

who gets to decide how to balance mental health service users' autonomy and agency alongside the demands placed on healthcare to treat and intervene with the mentally ill?

I use this chapter to take up some of these tensions. I first explore some of the historical and contemporary dimensions of psychiatric governance, resistance, and discourse, to provide some background for the theoretical and methodological framework that follows in Chapters 3 and 4. I then trace some of the emerging scholarship and activism, now called the 'Mad Movement' and 'Mad Studies', that is shaping critical work in mental health and serves as the departure point for this research. After mapping the tensions present in some of the critiques of the psy complex, I review how narrative approaches to research nuance or offer a counter-knowledge to dominant psy discourses.

### *The Origins and Evolution of Psychiatric Power and Exclusion*

Globally today, mental health patients' personal identities may be molded by the institution over time (Goffman, 1961), or they may resist the spoiled identity altogether, forcing their communities to accept their pre-institutional social position and self-construct (Prior, 1995). Other patients might carefully negotiate normalization and integration processes (Larsen & Topor, 2017; Olesen, 2016), battling unemployment, asociality, re-hospitalization, or programming and treatment plans that tend to carry the elements of the asylum back into their respective communities (Philo & Metzel, 2005; Topor et al., 2016). Some might approach varying madnnesses in a more positive light, seeing its expression as having the potential to teach us something about the world (Deleuze and Guattari, 2009; Farber, 1993, 2013; Laing, 1967). Despite the drawbacks of psychiatrization and hospital life, which can invoke fear, trauma, loss, and a lack of autonomy, some patients frame the

clinic space and atmosphere as a place of refuge to regroup and build resources during crisis (Ådnanes et al., 2018; Lidz, 2011; Rose, 2005).

Despite the advances of medicine to permit patients to express a kind of agency in their treatments and recoveries, psychiatry cannot be thought apart from historical regimes of social exclusion. As Porter (1996, p. 17) writes:

Lunatics, the argument went, ought to be confined because new management techniques would make them well. Given proper treatment their intellectual faculties would be repaired and their behaviour rectified...All the same, whether directed towards curing or merely securing, the rationales for confinement hinged upon a growing perception of the essential divide between normal reason on the one hand and delusion on the other.

This theme of exclusion is likewise central to Foucault's (1988) classic examination of madness in the age of reason. *Madness and Civilization* was not so much about trying to discover who was mad at a particular time or what constituted madness, but about how mad people were controlled and knowledge about madness rested on the authorities of truth regimes. After leprosy "disappeared from the Western world" at the end of the Middle Ages, a new figure emerges that is both dark and insidious: the *Narrenschiff* or 'Ship of Fools'. This "strange 'drunken boat' ...glides along the calm rivers of the Rhineland and the Flemish canals" (Foucault, 1988, p. 7) and carries aboard it the mad people of the cities of Europe. For Foucault this practice is "not just a general means of extradition," but the development of symbolic politics that seeks to purify European culture of its mad inhabitants.

It is clear for Foucault that mad people have been given no place in the age of reason. Their position has only ever been thought from a vantage wherein mad people are always-already excluded. It was their unwillingness to accept their own historical conditions of emergence that was central to Foucault's scathing critique of psychology

and psychoanalytic thought. Rather than acknowledge the contingent nature of its own intellectual genesis, psychiatric power has been predicated on an uncritical acceptance of the central claims of modernity: namely, that the reasonable individual subject is the ontologically stable unit of analysis and mad people have no place within this world (Bracken and Thomas, 2001; Bracken et al., 2012).

Rather than being an unfortunate but necessary precondition in the deliverance of psychiatric care, psychiatry only flourished “once, [and] not before, large numbers of inmates were crowded into asylums” (Porter, 1996, p. 17). Porter reminds us that historical sequestration was legally authorized not on the recommendations of doctors but on those of civil magistrates and political economic advisors. Life in the asylums of the 18<sup>th</sup> century was often grim and marked by monotonous routines and idleness, and many who filled these buildings were homeless, orphaned, or had committed a crime (Norris, 2017). Psychiatric practice thus emerged as a *consequence* and not as the *cause* of the sequestration of mad people. Psychiatric discourse had exclusion and sequestration inscribed within its very conditions of possibility, until institutionalization started to evolve during the era of Medicalization (19<sup>th</sup> century and on).

But slowly the prison-like atmosphere of these earliest years was being modified, reflecting developments in the surrounding culture...an era when scholars and politicians began considering society as the outcome of communal action and the shared responsibility of individuals rather than as the heritable domain of divinely appointed rulers. New emphasis was placed on education, science, and the use of reason to resolve problems...if people failed to achieve moral responsibility for their behaviour, society might then be faulted for not having provided them with sufficient guidance and support...Religion offered less hope of betterment than the pragmatic application of scientific method—given the right circumstances, troubled minds could once again become productive and happy minds. (Norris, 2017, pp. 142-143)

The term asylum was later replaced with hospital, and perspectives on civil commitment (involuntary hospitalization) considered less the problem of how to contain and restrain mad people, but how to best treat or cure them. The utility of involuntary hospitalization was evaluated in terms of how well it identified and treated mental illness, and could reintegrate patients back into their communities so they could find a place in society following hospitalization (Arnis, 1977). If people were excluded from the broader society because of their condition in this time it was not so much because they were mad but because of the perceived danger they represented to society (Federman, 2012). Psychiatrists were tasked with the mission of treating the mentally ill who could not always take care of themselves or were prone to violence, while those working from a rights-based perspective raised conflict surrounding the autonomy and civil liberties of the involuntary detained (Levenson, 1986).

Canter (2001) points out the complexities of allowing power to shift decisively in favor of the patient, allowing them to make free choices to make up their own minds about treatment options. He distinguishes charismatic power from coercive power (see Azeredo & Schraiber, 2016), arguing that each doctor draws on a distinctive consultation style to get patients to do what they want them to do. Canter argues that since all medical professionals do not alone recognize all medical truths, they should be open to paradigmatic changes in their field and be “sensitive” to power relations, rather than just eliminating medical power altogether. Patients likewise negotiate the power imposed on them by medical authorities; “at least some of the relationship between social structure and life outcomes flows through individual agentic capacities” (Hitlin et al., 2015, p. 164). But how strong does a mental health service user’s agency have to be in order to be trusted enough to become a lens upon

which one interprets their condition and life experiences (Thoits, 2006)? The spectrum of madness is infinite, so who gets to determine these thresholds, and what role does the service user have in delineating their take on experience? Do they have to return from a state of madness in order to circumscribe their narrative? Chapters 6, 7, and 8 will present readers with narratives that grapple with conceptions of agency by those who experienced serious mental distress and illness.

As the science of psychiatry evolved and became more professionalized, others grew weary of their legislative rights to control patients' liberty. Some people bought into the principle that patient autonomy and agency should be respected, and thus they began to question the necessity of hospitalization. The policy shift to deinstitutionalization that began in the 1960s—following the wave the psychopharmacology that started using drugs to treat and control mental disorder as opposed to other psychotherapies—relocated the responsibility for treatment of mental health service users from state-funded institutions to the community (Dej, 2012; Thompson, 2014). The idea was that people in distress could receive aid from their communities instead of being indefinitely and involuntarily incarcerated in hospitals. This approach meant to protect mental health service users' basic rights whenever possible, and implied that treatment in the community was a more humane approach to dealing with mental health issues (Davis, 2006).

Elshtain (1981) wrote that if deinstitutionalization was going to work, there would need to be widespread social supports in place, which of course did not occur. Conservative governments in both the United States and Canada during the 1980s took this a step further by equating autonomy with criminal responsibility (Thompson, 2014).

The reformist goals of North American deinstitutionalization were therefore not successful, and many people previously housed in mental hospitals became victims of ‘transcarceration’ as they simply moved from mental health institutions to prisons (Novella, 2008, 2010a/b; Stroman, 2003). In this sense, deinstitutionalization was not a natural outgrowth of the psychiatric apparatus, but rather part and parcel of austerity measures aimed at winnowing out the welfare state.

That being said, the latest mental health reforms, while still heavily operating under the influence and control of the bio-medical model, continue to try to improve the safety and efficacy of spaces designed to aid mental health service users’ recoveries (Pincus et al., 2016). Home Treatment Programs (HTPs), a form of community care whereby caregivers visit patients with serious mental afflictions (ie. hearing voices, hallucinations, paranoia) several times a day in their own homes, constitute the most recent form of deinstitutionalized care in Canada. With one notable exception (Cohen, 2008), the limited scholarship targeting their efficacy has focused on the clinical evaluation of decreasing symptomology and recidivism (Heath, 2004), which is problematic for people who view such experiences as temporal and not necessarily always/already bad when/if symptoms return, to varying degrees. Optimistically, participants in a new program called “Brief Intensive Home Treatment” in Québec City have told Canadian media that it is the most helpful and lifesaving care they have ever received (Wheeler, 2016). Similar successes have occurred in comparable outpatient programs in the UK (Tomar et al., 2003) and in Germany (Munz et al., 2011).

That is not to say that examples of these reforms have not been sharply criticized for their coercive elements. For example, community treatment orders (CTOs) are legally

binding orders in the provincial mental health acts that force patients to follow a prescribed model of treatment in the community, and if not followed can lead to institutionalization (LeFrançois, 2016). The UN has recognized that any form of involuntary and coerced psychiatric treatment can be experienced as highly traumatizing despite its prevalent practice across the globe (UN, 2015), and racialized and minority populations tend to be disproportionately placed on CTOs (Care Quality Commission, 2010). Other research strongly indicates that CTOs do not reduce the incidence or length of hospital readmission, alleviate the severity of symptoms, make the public safer, or help people in society cope better with their pain (Burns et al., 2013; Burns & Molodynski, 2014; Kisely & Campbell, 2015; Lawton-Smith et al., 2008; Maughan et al., 2014). Voluntary community-based services that do not use coercion or force, on the other hand, have led to more positive outcomes (Dreezer & Dreezer, 2005). Others have questioned how the distribution of ‘improved’ drugs to treat mental illness, which are supposed to reduce the side effects of older psychoactive medication, perpetuate neoliberalism and the corporate pharmaceutical regimes that ultimately have more interest in selling drugs and controlling populations than developing (if possible) more long-term treatment plans for mental illness (Breggin, 2008; Farber, 2013; Whitaker & Cosgrove, 2015).

The historicist readings and critiques of psychiatric power remind us that medicine’s past is built on some coercive foundations, but alongside the goal of treating people in distress, who were perceived as violent, or who did not fit into the prevailing norms of society. Nevertheless, psychiatry and psychoanalysis survived the anti-psychiatry movement of the 1960s (as discussed in more depth in Chapter 3). Tensions and coercions of the past are still evident in some current psychiatric practice, as medical experts today can still

forcibly exclude by incarcerating, restraining, sedating, secluding, and medicating people in hospitals as long as the doctors' decisions are not found to be punitive in nature and in the best interests of the captive mental health service user (Bernheim, 2014; Federman, 2012; Holmes et al. 2014; Szasz, 2014; Fennell, 1996; Neilson and Chaimowitz, 2015). There exist dynamic controversies regarding informed consent to treatment in psychiatry (or lack thereof). Even with the recognition that many mental health service users are autonomous and quite often can make good decisions about their care (Neilson & Chaimowitz, 2015), a great deal of trust and authority is given to psychiatric experts to compulsorily treat mental health service users on the principle that their medical judgments are better than the person experiencing mental illness. Many times, this may be the case, but how can we acknowledge capacity issues without infantilizing service users? The question of how, if at all, can we exact a threshold when people can no longer make decisions about their health falls outside of the scope of this dissertation. However, friction remains over the ethics of care and responsibility owed to mental health service users who are excluded from decisions about their care.

### *Tensions with Pathologization and Representation in Mental Health*

Now that I have examined some of the history shaping the tensions of psychiatric power, governance and interventions, it is necessary to examine the texts upon which psychiatry draws most of its power and authority. This section of Chapter 2 will take up some of the assumptions and purposes of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)—a book Burstow (2016) refers to as a “boss text”—which has become widely regarded as a legitimate tool to define encounters with mental illness and circumscribe appropriate treatment. The DSM, even amidst its drawbacks, may be useful at

identifying mental disorders. Chapters 5 (especially), 6, and 8 of this dissertation will move beyond the clinical definitions of mental disorder to narrate experiences of madness that cannot be fully captured by the reductive definitions present in these texts.

The first two editions of the DSM printed in 1952 and 1968 classified mental illnesses (and non-normative behaviours) according to psychoanalytical aetiological theories. What this means is that the texts focused on trying to theorize what the underlying causes of the disorders were, rather than explore and classify symptomology, that is, mental distress *experiences*. The third edition of the DSM in 1980 “replaced the theoretical and aetiological system of classification...with an atheoretical and purely descriptive approach to classification, which has remained the favoured methodology in subsequent editions of the DSM” (Tsou, 2016, p. 406). Psychiatry then focused on looking for indicators to classify disease rather than dig into the patient’s life history to come up with a theory of why they are suffering the way they are. The DSM-III was heralded by practitioners as revolutionary for its ability to produce reliable and testable criteria for mental disorders; specifically a cluster of various symptoms that could help explain biological, neurobiological, and molecular mechanisms occurring and interacting at multiple levels to produce unwell states of being (Clegg, 2012). One limit of the DSM in a descriptive form is it has difficulty classifying and explaining causally naturally occurring disorders such as depression and schizophrenia, but those illnesses, for many people, still remain real and tangible to those observing or living them (Tsou, 2016). Though grounded in years of clinical research, another assumption is that clinicians must believe that the cumulation of descriptors and criterion are in fact a conceptually sound, uncontroversial, and valid basis for determining the existence of a disorder (Wakefield, 1992).

While the DSM remains a useful text for practitioners trying to diagnose and treat people from their mental illness, like any other discourse or narrative, the text is conceptualized and circulated through a process that is shaped by political, gendered, cultural, and socio-economic forces (Clegg, 2012; Reuter, 2006, 2007). For instance, the gendered disposition of psychiatric pathologization is evident by the disproportionate number of women who are prescribed psychotropic medication or diagnosed with a disorder because they express gender in ways that are deemed suitable only by men (Russell, 1995). The introduction of the DSM-V, which was created in part to recognize the degrees to which culture might influence how mental illness is experienced and understood (Wakefield 2016), still forces patients to absorb other clinical definitions, such as depression, in order to receive attention from the mental health system. This exact tension shaped the recent debate over whether the DSM should redefine gender identity disorder as gender dysphoria or abolish the term altogether. Some members of the trans community believe it is important to have a label that acknowledges their clinical and mental pain while still attempting to debunk ideas that being trans is an illness (Drescher, 2013). And finally, some people describe psychotic hallucination or depression in terms of its rate, content, burden, and phenomenology differently in Western countries as opposed to other parts of the world (Bentall et al., 2012; Connor & Birchwood, 2013; Hopper, 2007; Jenkins & Barrett, 2004; Jenkins, 2015; Kleinman & Good, 1985; Luhrmann et al., 2015).

Critiques of the DSM-IV have extended to account for the sometimes arbitrary and emotional ways upon which disorders become classified and applied to people in psychiatric practice (Cohen, 2013; Wakefield, 2016; Wilson, 1993). Thoits's (2012, p. 201) term "emotional deviance"—defined as "persistent, repeated, or intense violations of societal

feeling or expression norms, where emotion management efforts are often ineffective”— indicates there is a perceptive (unphysical) threshold people cross when they communicate thoughts and identities that others recognize as constituting mental illness or sickness as opposed to just say, unusual forms of expression and distress. Her content analysis of the 351 Axis 1 and Axis 2 disorders located in the DSM-IV finds that 101 (30.5%) of these diagnoses are primarily established by the recognition of culturally constructed deviant feelings or emotional deviance. She argues that some mental illness construction and labelling begins when we lose emotional control, disturb others by expressing emotions that are unruly, disruptive, excessive, and unsightly (i.e., anger, frustration, nervousness, fear, melancholy, worry, apathy, laughter), or fail to perform emotions that societies deem to be appropriate given the circumstances. She and others (Kirmayer et al., 2015) are quick to point out that the criterion that comprises definitions of mental illness as well as how it is experienced by people are heavily shaped by cultural constructions of normal behaviour and our underlying ideological orientations.

What this critical approach might ignore and even try to mitigate are the biological agents and chemical imbalances that accompany extreme distress (i.e., psychosis), which some might see as universal in cause despite being subjective in experience. Given that many experience symptoms of mental illness differently, and there is a general lack of clarity and consensus over how mind problems or experiences are put into medical terms (Rogers & Pilgrim, 2010), it is still difficult to precisely pinpoint the experience of mental illness as solely the result of physical and neurological disease or imbalances. Mental illness was historically described as a “disease of the nerves” (Foucault, 2006, p. 139) that could take on “animal” characteristics and bodily dysfunctions ranging from violence, deviance, and

instability to poor hygiene. Today, the medical model holds that mental distress becomes an illness when it surfaces from a biochemical disorder, genetic predisposition, or virus (Tew, 2005). This perception tends to overlook or take as seriously the social circumstances that bring about mental illness and crises (Goffman, 1961; Laing, 1971). Even in cases where there is evidence that an “illness” may be grounded in social, cultural, and interpersonal contexts, such as the case with post-traumatic stress disorder and perinatal depression (Becker, 2004; Lara-Cinisomo & Wisner, 2013), the medical model prevails by implying that there is a biological disposition to PTSD that is prompted by a traumatic event. Women, racial minorities, impoverished, and homeless populations are more likely to be diagnosed with a mental disorder than are privileged populations (Davis, 2006; Dej, 2012; McKenzie & Bhui, 2007; Muenzenmaier et al., 2015). The main issue with over-diagnosis and over-categorization of mental illnesses is that they may be disguising other social forces behind people’s poor treatment, stigma, or mental illness, and which this dissertation explores in more depth, especially in Chapter 7.

### *Psychiatric Resistance and Activism*

Online activism and social media networks are calling for critical examinations of how people construct meanings around disability and mental health (Burch, 2017). Counter-narratives that challenge public attitudes about disability and disablism have garnered media attention and given disabled persons a voice in debates that they would normally be excluded from (Theodorou & Mavrou, 2017). Thus stories about mental distress and encounters with the mental health system begs further analysis and demands the public’s attention, compassion, understanding, and respect (Tew, 2005). This section of Chapter 2 will discuss the emergence of “Mad Studies”, which seeks to mobilize the voices of mad people to

influence psy-discourse and belief systems about mental health. I then explore some of the limited literature that narrates mental health experiences from the perspectives of service users, which serves as a justification for the narrative methodology I outline in Chapter 4.

Contemporary forms of psychiatry gain their legitimacy through notions of empirical objectivity, whereby knowledge is produced ‘independently’ of social and cultural forces and ideologies (Faulkner, 2017; Macdonald et al., 2018). From this perspective, psychiatry can be framed as apolitical, despite its connection to global capitalist systems and growing pharmaceutical regimes (Whitaker & Cosgrove, 2015). Such ‘expertise’ and ‘distance’ from the lived experiences and knowledge of those labelled mad and mentally ill limits our understandings of mental distress and behaviours and its potential social or spiritual causes (Coles et al., 2013; Faulkner, 2017; Pilgrim, 2014). Because of the privileged knowledge of mental health professionals and suppression of other forms of knowledge on mental illness and distress (Cohen, 2016), less is known concerning how service users resist the psy-apparatus and institutionalization.

In response to the many tensions and controversies in the biomedical model of treatment and recovery, a number of scholars, activists, and radical psychiatrists—some of whom identify as service users—have spearheaded a social movement to advance the protections of mental health service users, validate and celebrate their experiences and cultures, and debunk some of the legislative, symbolic, and discursive powers of psychiatry (LeFrançois et al., 2013). This movement, cleverly coined “Mad Studies,” seeks to develop an alternative praxis and epistemology to the medical model of psychiatry by exposing the values and presuppositions that shape psychiatric thinking and practice (LeFrançois et al., 2016), and by problematizing the “ontological assumptions about what madness is, how it

comes about and how it should therefore be treated” (Rose, 2017, p. 778). Contrary to psychiatry’s objective ‘independence’ from social forces, mad studies re-inscribes psychiatric practices within the social, institutional, and political forces that shapes all knowledge.

The most prominent way scholars can ‘do Mad Studies’ is by privileging service user experiences as a form of knowledge and insight into the ways they experience suffering and social oppression (Beresford, 2000; Mulvaney, 2000). Such a positioning works hard to not disqualify mad bodies as irrational, incoherent and deviant, and thus unworthy of full citizenship and ‘healthy’ status in our societies (Beresford, 2013; Spandler, & Anderson, 2015). More scholarship is needed by service users and critical professionals that interrogates psychiatry and exposes its hidden inequalities and systemic practices of epistemic violence (Burstow, 2016; Russo & Beresford, 2015; Timander & Moller, 2016; Watermeyer & Görgens, 2014), which refers to the “ways certain persons or groups within society are disqualified as legitimate knowers at a structural level through various institutional processes and practices” (Liegghio, 2013, p. 123). Even amidst the concern that doing ‘science’ excludes people who cannot live up to positivist criteria of evaluation, there is still a need for service user work to be rigorous in order to be considered credible, increase its impact, and find ways to account for the ideological and epistemological differences in class, gender, ethnicity, disability, and sexuality that shape mental distress and encounters with the mental health system (Campbell, 2009; Jones & Kelly, 2015; Rose, 2017; Timander & Möller, 2016).

Feminist standpoint epistemology, as a relevant framework of inquiry, privileges situated knowledge and challenges the notion of a universal and value-free knowledge (Harding, 2004; Rose, 2017). All research stems from a particular perspective, and by

recognizing them we become more able to resist dominant notions of correctness, validity, and legitimacy, and reclaim authority through alternative discourses (Kokushkin, 2014; Rose, 2009). Oppressed people's perspectives can have greater insight into knowledge than dominant perspectives because "those existing in these locations not only have access to the communities developed by those with similar identities, but they have to navigate the realms that are put in place by the dominant groups" (Keating, 2016, p. 42).

Rather than succumb to the mainstream critiques of relativism, standpoint theory finds objectivity through its awareness that knowledge produced is partial. Standpoint positioning encourages researchers to find ways to uncover their value systems and ideologies (i.e., reflexivity), instead of hiding behind them, so that our ideas can be questioned and positioned in ways that do not normalize and pathologize marginalized groups (Haraway, 1988). The end result is a 'stronger objectivity' (Harding, 1993) because marginalized groups can toil both with mainstream discourses as well as the ones produced through their own experiences (Rose et al., 2018). Animated by this framework, this dissertation will shed light on how mental health service users "take back control of their stories to make [their] own decisions about what [their] stories say" (Faulkner, 2017, p. 507).

Working within the feminist standpoint framework, Burstow's (2016) recent edited volume tells readers about how mental health service users and even agents of the asylum continue to face victimization, suppression, stigma, (re)traumatization, and injustice once they become entrapped within psychiatric discourse and practices. It is written primarily by graduate students, service users, activists in the Mad Movement, former 'caregivers' and people employed by the mental health system. Burstow herself, unlike several people in the mad movement or even the book, does not take a Mad Studies approach but instead argues

quite vociferously against both mad studies and the mad movement. She is an antipsychiatry activist and academic that takes a staunch abolitionist approach to psychiatry. The book indicts some psy-professionals who mobilized psychiatric knowledge and practices to degrade, torture, and gravely harm others. As such, it serves to (1) educate skeptics; (2) bolster activism and solidarity in the Mad Movement; (3) vindicate people who encountered psychiatric violence and coercion who often experience their struggle in a void of isolation; (4) provide hope to the many disgruntled professionals working in the mental health field who question their assumed role in helping people; and (5) draw ferocious critique from countless agents who wholeheartedly defend the idea that psychiatry can/will/does help/treat/cure sickly people, whether with complete, partial, or entirely without our consent.

In the volume, Gold (2016) discusses how Dr. John Zubek, a leading psychologist at the University of Manitoba, spent a great deal of his illustrious career torturing his students in experiments (some of whom he coerced into participating) vis-à-vis sensory deprivation, isolation, captivity, and immobilization. The chapter vividly showcases how Zubek exhausted his creative capacity to develop ‘techniques’ that could pinpoint the breaking points of subjects in interrogation settings. These findings, alongside a number of other ‘researchers’ doing similar ‘work’ in the middle of the century, nourished the myriad networks of secret service and intelligence agencies who wanted techniques to extract information from unwilling subjects, or influence those who they felt needed to have a sudden change of heart. What is more disturbing than the very thought that these sick experiments actually took place in the bowels of a Canadian university is the fact that they were funded and rendered ethical by our institutions and research boards. The Canadian Defence Research Board (DRB) provided Zubek with \$18,000-21,000 of research funding

per year between 1959 and 1974 for his sensory and perceptual deprivation branch of his experiments.

Not only do we learn from this how problematic psychological experimentation is still ongoing, Burstow and Adam (2016) reveal how established mental health organizations use forms of bureaucracy and employ tactics of deceit to hide their actions from the public. In 2012, the Centre for Addiction and Mental Health (CAMH) in Toronto placed ads on Craigslist to recruit depressed, desperate, vulnerable, and impoverished people at the end of their rope to take part in ‘safe’ electroshock ‘treatments’ (experimentations), in exchange for a few hundred dollars. After Burstow and her small army of activists challenged CAMH to stop what they were doing, and make changes to the research ethics boards that allowed this ‘research’ to continue, we are left to question if the research *actually* came to a halt, and if meaningful reforms materialized in relation to their ethical processes and approval boards. Why? Because people doing psychiatric and psychological research not only get to decide what is moral and immoral, right and wrong, ethical and unethical (and determine if there has been a breach), but there are no current and overriding governmental laws that force them to *publicly* justify the purpose of their experiments, or make known whether they completed a meaningful investigation of their wrongdoings.<sup>2</sup> Although the CEO of CAMH informed Burstow that they stopped recruiting people for ECT who otherwise would not have been recruited because they did not have a prior clinical justification, it remained confidential what the processes were overseeing their experiments and regulations.

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<sup>2</sup> The ethical guidelines overseeing the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada clearly stipulate that “research subjects must not be subjected to unnecessary risks or harm”, and harm, both physical and psychological, is defined as “Anything that has a negative effect on the person’s welfare” (Burstow, 2016, p. 27).

Indeed, much of the literature on organized activism in mental health focuses primarily on policy development and processes of engagement between affected groups and psychiatric agents (Montenegro, 2018; Pilgrim, 2005). Beyond direct forms of action and activism, Montenegro (2018) recently explored how service users disengaged and distanced themselves from the psy apparatus, which positioned themselves outside of the legibility, approachability, and descriptive ambitions of the mental health system. Some studies discuss the logics of professionalization (El Enany et al., 2013) and how those working in mental health are just as prone to psychiatric power and oppression as service users (Chapman et al. 2016; Tosh & Golightley, 2016). All of this is not to say that labelling and diagnosis in its totality is always-already malicious and flawed, as some biomedical narratives and practices can offer comfort and reassurance to service users (Rose, 2005). It is also documented how secondary stigma is both resisted and welcomed by some mental health service users (Griffiths et al., 2015; Krupa et al., 2009; Probst, 2015; Sibitz et al., 2011). Chapters 6, 7, and 8 will take up service users' varying identities and relationships with psychiatric labelling and governance.

I do not intend that the heavy criticisms of the psy-industry I have posed thus far give readers the perception that I am a psychiatric abolitionist or anti-psychiatrist. Nor do I support the pessimistic notion that mental health intervention has a coercive future. That is not my argument, and this point will be reified in Chapter 9 when I discuss the practical implications and ways that the mental health system can improve based on this research. Rather, by exploring these critical relations with the psychiatric apparatus, I have sought to justify the need for mental health users' voices to be taken seriously, which I argue can provide extensive knowledge about mental health and illness beyond clinic definitions and

research shaped by actors who hold a great deal of power. The controversial issues and struggles in the mental health system should be read with some degree of caution, as no system is perfect, and there is no doubt in my mind that the mental health system saves lives. In fact, some of the narratives presented in this dissertation will at times appraise the noteworthy accomplishments of psychiatrists and mental health professionals to help service users recover and gain a better understanding of their illness.

What does a mental health system look like when it takes these criticisms into account, and tries to overcome issues of power, domination, and social control? Consider Dosse's (2011) discussion of the *La Borde* clinic, opened in 1953, which Guattari himself attended in the town of Cour-Chevey in the Loire Valley of France. Founded by psychiatrist, Jean Oury, the facility still operates today, and is an example of an institution where patients actively take part in its operations. The clinic rejected the traditional approach of isolating people with psychiatric disorders and instead believed that mentally ill persons should mix with 'normal' people, "without forgetting that psychotic patients need medical treatment" (Dosse, 2011, p. 40). Everything about this hospital was different. It had extensive gardens that patients were free to roam through, as they had spatial permeability. The design of the institution was anti-bureaucratic and communitarian. Nurses wore casual clothing and provided patients with more humane and less decentred care. Staff members' tasks, responsibilities, and salaries were all shared since they oscillated between manual labour, housekeeping, running workshops, preparing theatrical activities, and intellectual work, as it was not uncommon there for both patients and staff to be encouraged to study philosophy, nurture their creativity, and develop new forms of subjectivity. Perhaps above all, delusional behaviour was not fetishized; Oury believed that patients' words held some truth and, while

recognizing illness, *La Borde* still sought to seek out the creative elements of madness and be attentive to its transcendental dimensions.

While all of this was going on, *La Borde* still suffered from the downfalls of any institution. Fights would erupt between patients, and Guattari, who became a leader and organizer at *La Borde*, had to sometimes rely on his judo skills to quell any violent tendencies. Still, there was an emphasis on resolving disputes and problems through discussion, rather than force. Patients were likewise encouraged to attend the workshops, and Guattari would occasionally be quite authoritarian with others about the need to get out of bed and become involved in the scheduled activities. In the presence of these power dimensions, *La Borde* demonstrates an active desire to create a mental health utopia and space where self-determination and freedom can occur alongside psychiatric treatment.

### *Mental Health Stories as Counter Knowledge*

Some of work within Mad Studies emphasizes that personal understandings of mind problems and afflictions can digress substantially from dominant biomedical interpretations (Cohen, 2008, 2015), and some accounts can wield enough power to change culture and institutional practices, whether they circulate in policy documents, everyday talk, or various forms of media (McKenzie-Mohr & Lafrance, 2017). Mental health narratives of service users challenge the traditional approach to clinical research by arguing that voluntary and involuntary users of healthcare systems are privileged authorities on their own state of being (Church, 1995; Cohen, 2008; Lafrance, 2014). This work has provided insights into the less known ways people define and overcome their afflictions through, for example, spiritualism (Farber, 2013), self-coping, self-recovery, and alternative treatments (Adame, 2014; Cresswell, 2009; Crossley & Crossley, 2001; Farber, 1993; Watson, 2012). Most narrative

approaches to mental health are anti-modernist because they doubt the possibility of knowing any context-free truths (Bracken & Thomas, 2001). Outsider interpretations are useful to people who experience mental illness when they feel that expert interpretations are superior to their own, and that belief in it can alleviate their pain and anguish (Kirmayer, 2000). Hence any practices or treatments conceived through narrative-based knowledges still have to ensure that in addition to making psychiatric practices user-centred, they are also safe, not too high on ideals, and hold practical utility.

To help grapple with the largely unanswered epistemological tension of how narratives can “engage with the ‘real’ world whilst also maintaining its distinct focus on subjectivity” (Fleetwood, 2016, p. 174), narrative waves in mental health fields have spearheaded distinct and alternative therapeutic practices. These people acknowledge that mental illness would gain better definition and insight through the stories that often call into question the tidy picture of mental illness that is presented in versions of DSM and institutionally reproduced by some psychologists and psychiatrists (Angus & McLeod, 2004; Carless & Kitrina, 2008; Freedman & Combs, 1996; Grant et al., 2015; Kogstad et al., 2011; Stone & Kokanovic, 2016). Psychotherapists who practice narrative therapy as well as narrative researchers shift away from traditional psychotherapies and pharmaceutical interventions to assisting people in reimagining their lives by revising their internalized and unique life histories to be more “inclusive and appreciative of clients’ personal power and responsibility” (Polkinghorne, 2004, p. 53). Polkinghorne (2004) describes narrative therapy as a practice in which lives are understood as unique histories that unfold through the act of storytelling. People construct their lives and give meaning to the actions they take and the events that happen to them by sharing stories that are often heavily internalized, shaped by

culture, and—most problematically—constrictive and blaming. How we interpret the extent to which events positively or negatively impact our lives can limit or expand our sense of possibility for future actions. Narrative therapies help people re-author their life histories in ways that give positive meaning to what some might experience as hardship by emphasizing areas of their stories that appreciate their clients' agency, empowerment, and responsibility (Freedman & Combs, 1996). More inclusive and open-minded interpretations of life occurrences, plots, and circumstances that speak more to the breadth of life can uncover veiled significances to events that may not have been previously considered in other clinical settings.

Freedman and Combs (1996) assert this approach to counselling is not a posture of authoritative truth; more specifically, stories should be looked at as a work in progress where clients experience control over their healing process instead of established and stable certainties (Bruner, 1986). They reject the positing of mental illness as synonymous across all contexts and highlight the dehumanizing effect that mental health research has on people when its goal is to reduce and respond to psychiatric disturbances with predictable, generalizable, and standardized measures. Not only should narrative therapy seek to alleviate mental illness and pain, but it also must tackle the secondary traumas and harms people experience as a result of psychiatric treatment, abuse, and coercion in clinical settings.

In addition to helping people recover from mental illness (Nelson, 2001), illness narratives have provided researchers with insights into how service users manage their conditions and other people's perspectives on them. Countering positivist epistemologies that investigate postnatal depression as a disease and deficit, Stone and Kokanovic's (2016) narrative study depicted women as challenging antithetical discourses that place a duty on

them to be healthy and good mothers. Their stories reflected their own language about pain, sadness, early motherhood, and identity, as they constructed themselves as unwell parents in recovery instead of bad and deficient mothers who are unable to live up to their responsibility to care for their children. Men who participate in sport and exercise have successfully mobilized experiences with severe mental pain in storytelling form to gain support, renew hope, reconstruct their identities, and better their sense of self (Carless & Douglas, 2008). Narratives about the embodied experience of battling mental pain within the intense capitalist, ableist, and sanist structures of society (Breggin, 2008; Deleuze & Guattari, 2009) relates to Spencer's (2012) framework of how bodily, chronic, and everyday pain is managed in subcultural and gendered settings. Put more simply, people who experience varying forms of internal pain associated with mental illness can experience a similar resiliency that fighters express. When put to the test by auditory and visual delusions and internal warfare—voices that are only real to the person hearing them and which can materialize into an entire speaking society—my experience is that the mind, much like the bodies of fighters, can “harden...and turn it into a weapon” (Spencer, 2012, p. 120). Getting through mental pain outside of and within the psychiatric system is a journey laced with difficulty, revenge, anger, frustration, highs, lows, regret, failure, and courage. In Chapter 5, I explore in more depth how I both needed and resisted the mental health system to transform back into a body that is manageable and less dangerous.

Another more notorious example includes Kleinman's (1988) book, *The Illness Narratives*, which is one the earliest and most comprehensive anthropological works that place people's life experiences and perspectives as central to understanding mental affliction. He argues that how illness meanings become interpreted in medicine must account for the

complexities of personal relationships. More importantly, this task should not be seen as secondary to ‘curing’ but “constitute, rather, the point of medicine” (Kleinman, 1988, p. 253, as cited in Cohen, 2008, pp. 36-37). Kleinman (1988) claims that psychoanalytical understandings of mental distress became as popular as biological/psychiatric discourses because practitioners (and then broader populations) believe there are deeper meanings to uncover behind most illness stories, even if there is no clinical justification. Quests to further psychoanalytic reality, in his view, can be just as dehumanizing as the mundane reductionism of a relentless biomedical investigation.

Becker (1995) makes the same point when he rejects post-traumatic stress disorder as pathology because some people who encountered human rights violations who are labeled as having PTSD present narratives that are not disordered. A great deal of experiential research on trauma and mental health in general has had to borrow the perspectives put forth by psychiatry in order to gain legitimacy in the health field, namely “the focus on the individual, the theory of a damaged self, and the need for psychotherapy” (Larrabee et al., 2003, p. 36). Without these dips back and forth between the study of individuality, pathology, and relationality, Herman (1992) believes work on trauma would have disappeared. If narrative researchers established that some afflictions such as PTSD are grounded in social and not pathological contexts, patients would still be forced to absorb other clinical definitions such as depression in order to receive attention from the mental health system.

Mental health service users’ capacities to overcome the constrictive and distorting meanings imposed on them by those who adhere to the medical model’s discourses on mental distress are also evidenced in Farber’s (1993) revolutionary book, *Madness, Heresy and the Rumor of Angels*. In largely uninterrupted form, he presents the stories of seven service users

who were victims of psychiatric abuse and labeled by the mental health system as psychotically disturbed, delusional, clinically depressed, and unaware of their risky circumstances. Yet how Farber (1993) presents the narratives emphasizes the service users' resiliency and escape from the marginalizing and precarious circumstances many people labeled as mentally ill encounter, such as the debilitating effects of psychotropic medication (ie, personality loss), unemployment, and non-relationality. As one former psych-ward patient recalled, "There's nothing more depressing than having somebody tell you your brain isn't working right...They wanted to limit me to a mediocre existence...They never asked me what my problems were when I went in" (Farber, 1993, pp. 90-91). The participants are depicted as socially responsible leaders who reflect a keen awareness of the inequalities of society and pose a strong determination to change the world and how people conceive of it. One woman described in his book the benefits of her visions she endured for three months following her departure from a mental hospital.

I felt a connectedness with every other living being, with everything. And I felt at times I had the ability to know what people were feeling. It wasn't merely a thought of my relatedness to other beings, it was an experiential knowledge. In normal consciousness for me there is such a thing as a stranger, there is such a thing as a person that I'm not related to in any way. But in this other consciousness I am very well aware of my relatedness to people just as I normally am with my own brother, my mother or my father. I felt very good...I knew that what was going on was valid for me (Farber, 1993, pp. 82-83)

When juxtaposed to the narratives Farber constructs as belonging to most mental health experts, which can demean the narrators through assumptions of mental illness and symptomatology, readers are left with two binaries on which to judge the storytellers. We either see the patients as irresolvable, sickly, and disturbed victims, or as heroic prophets sharing a hopeful tale of conquest, spiritual vision, existential crisis, self-discovery, and triumph over their descent into madness. Without sounding centrist (as discussed in more

depth in Chapter 3), this dissertation is situated at the crossroads of this binary. Mental health service users have a right to be viewed as sickly and benefit from the rights of this label, but they also ought to have their dignity respected and their views on their own illness not taken for granted in both clinical and broader societal settings.

In Farber's (2012) later work, *The Spiritual Gift of Madness*, he reflects extensively on how historical civilizations and non-western cultures view mad people as in touch with otherworldly realities—modes of being that could reveal truths and meanings most of us do not yet know or engage on a serious, everyday level. Although Tenney (2016) likewise thinks about mental health beyond scientific terms, her spiritual exploration of madness raises tension. While she draws on Farber's (2013) ideas of spirituality, it is necessary to admit that alongside that reality is the 'badness of madness;' there are mysterious, dark, and ineffable energies that cause unspeakable suffering and spiritual isolation, and leave our loved ones in the dark, wondering what to do. Consider a story told by a person who experienced psychosis in one of Farber's (1993) earlier works (which Tenney cites in passing), after she escapes her psychiatrist's office:

And I found myself standing outside on the sidewalk. And I was directed to look to my left and out across a field. I did, and my eyes landed on three crosses of a church...And I knew I was supposed to go there. And I started walking across the field. My mother, I heard her calling me. I wasn't going to look back. I just kept walking. And I felt her coming, and I turned and I saw her coming across...there was a highway and another field between me and the crosses. I turned around and my arm went up and pointed at her and my voice said, "Get away from me, Satan!"...I was not possessed, because I was conscious and I agreed with what was happening, even though it sort of puzzled me, in a way...And after I said that to her I climbed over the fence and I walked across the four-lane highway, and I was aware that normally I would look to the right and left to see if there were any cars coming. But I did not turn my head to the right or the left because I was aware, I could feel, that there were no cars. Obviously there weren't; I did not get run over, nobody put their breaks real fast or anything. (pp. 73-74)

Returning to the points raised earlier about service user agency, we know from this story what the service user believed was real. But what must it have felt like for a mother to watch her daughter, whom she *believed* was ill and unable to control herself, cross a four-lane highway without looking, uttering what could have been her final words to her, “Get away from me, Satan!” Can we assume that she knew what was better for her at that moment than her mother or psychiatrist? Decisions have to be made, sometimes quite quickly, over concerns for a patient’s life and danger to themselves or others. Mental illness is full of thresholds, and sometimes the escape from reality is so detrimental to their livelihood that they must be brought back and managed. This problem begs the questions: When is one supposed to know when to let madness breathe (Spandler, 2014), and see if it will digress? How can that be managed in an overloaded and institutional system that must manage millions of mental health problems everyday? And who gets to decide this? In the analytical chapters that follow, I will engage this threshold and try to identify points of rupture and spectrums that mental health service users work with to guide the shaping of their identities, recoveries, critiques, and appraisals of the mental health system.

Although far less explored, family members include some of the other agents who accommodate and resist the dominant discourses on mental illness. Boschma (2007) found that family members defined membership and dependency of vulnerable members in different ways and with deeper meanings than institutional case records and histories asserted. Those left to spectate at what, for some, is very real torment, are left questioning if/how they should bring us back. And while there is much to challenge with respect to the psy apparatus and its implications for people’s identities and proposed solutions to illness (psychotropic medication, hospitalization), mental illness narratives are not necessarily

‘false’.

While the boundaries between narrative as a therapeutic practice and sociological method are blurred, what is clear from this literature is that the integration of sociological perspectives and humanist approaches towards recovery can work together to negotiate tensions between the diagnostic labels and illness definitions, while assisting to cultivate better understandings of the recovery process (Pederson, 2013; Watson, 2012).

Understanding what mental illness is in its infinitude and helping others overcome it is not inseparable. The large body of work raises a tension for narrative researchers in mental health: is it acceptable to take people’s stories at face value? Strictly speaking, can stories be “good at making simple what is complicated” (Sandberg & Ugelvik, 2016, p. 129) because sometimes people mean exactly what they say? How meaning is made through narratives – namely how we understand and communicate what mental illness is outside of clinical settings, and how we relate our own experiences to those of others – can only be partially uncovered by narratives (Doucet & Mauthner, 2008; Randall & Phoenix, 2009). This is because we are limited by the stories that others share with us, and the stories we remember in different ways at different points in our lives. Narrative researchers have to strike a sensitive balance between analyzing the stories in ways that maintain the authenticity of the participants’ voices, while still presenting the research as a contribution to the broader movements aimed at bettering (self) recovery programs and desisting coercive institutional practices. Researchers are bound to have their own preconceptions about mental health (critical and/or not) and therefore are suspect to take words out of their context or not relay the precise meanings that were intended by their participants. Since mental health stories hold the potential to build and develop layers of meanings that tend to surface when others

feel loved and trusted (Gair, 2012), the stakes are high when considering the tensions present in the creation of mental health knowledge and claims. It is through the power of stories that this dissertation will navigate, unravel, mediate, and demystify these points of consideration and tensions.

### *Chapter Summary*

In this chapter, I traced the many dimensions of psychiatric power and identified the point in history when medical experts were given control over mad people and knowledge about madness. Medical experts use(d) containment, practices of restraint and seclusion, and moralist discourses to claim authority over what constitutes the truth about madness and therefore rationality. When psychiatry termed mad people as potentially dangerous, the discipline gained legislative authority and forever linked psychiatric power to state power. Those who fight for the autonomy of patients must always confront the binding legal power that psychiatrists hold – their statements of truth carry much power in western ontologies. In the face of these tensions, I have shown the struggle that doctors engage in to still treat mental illness. They are faced with the task of managing mental pain while much of the world stigmatizes and fears it. And the text they draw most of their power from – the DSM – continues to aid them in identifying and diagnosing mental disorders, albeit there being issues with its social, cultural, economic, and gendered applications.

Following this historical overview, I examined the field in Mad Studies and its great work resisting some of the coercive authorities, discourses, and practices of the psychiatric enterprise. The Mad Movement reminds us how knowledge is constructed about madness, and by deconstructing its preconditions, enlightens readers not to miss out on the glories and insights that mad bodies provide. Mad scholars and activists have also told us powerful stories of trouble caused by psychiatrists; tortures and injustices that continue to escape the public's eyes. And lest we forget the work of

narrative scholars and therapists who have taken seriously the stories of service users, and helped them to transform their lives and overcome the traditional practices of biomedicine that have left some scarred.

I have asked many questions in this chapter, some of which our stories cannot fully answer. But what they all revolve around is my search to identify the spectrums of service user agency, so that I can make an argument about our capacity to make claims about mental health and the mental health system. I ask readers now to interrogate with me the practices and ideas of psychiatry, and learn from the service users' stories how we can take our mental health into our own hands, and navigate the boundaries madness and our complex relationships with professionals.

### **CHAPTER 3: PSYCHIATRIC POST ANARCHISM: A PRAXIS FOR RESISTANCE AND CONFORMITY IN THE MENTAL HEALTH SYSTEM<sup>3</sup>**

~ Madness need not be *all* breakdown. It may *also* be breakthrough...to be mad is not necessarily to be ill, notwithstanding that in our culture the two categories have become confused...From the alienated starting point of our pseudo-sanity, everything is equivocal...The madness of our patients is an artifact of the destruction wreaked on them by us and by them on themselves. Let no one suppose that we meet 'true' madness any more than that we are truly sane. The madness that we encounter in 'patient' is a gross travesty, a mockery, a grotesque caricature of what the natural healing of that estranged integration we call sanity might be. True sanity entails in one way or another the dissolution of the normal ego [emphasis added]. (Deleuze & Guattari, 2009, pp. 131-132)

Alongside institutional concerns, tensions, and indignities, the ability of mad people to resist those who conceive of madness as an ontology or space that must *always* be fixed and exited begs further attention. As described earlier, psychiatric power is problematic for people who do not want to be 'treated,' do not feel that they are ill or suffering, or if they are sick, believe that the treatment, forms of institutionalizations, and stigma are, in many cases, worse than the onset and continuation of symptoms. Then, of course, there is the complex, messy, ineffable, and potentially irreducible extreme (Brown & Tucker, 2010)— those individuals who may sometimes desire intervention on their own terms (such as in the community instead of a hospital), or at other times want complete intervention by system officials when the 'badness of madness' overwhelms them and compromises the safety of themselves or others.

In this chapter, I take up my earlier research question theoretically by asking: what kind of subversive praxis can acknowledge madness as a source of both ruin and

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<sup>3</sup> Sections of this chapter have been reprinted from Johnston, M.S., & Steckle, R. (2018). Psychiatric post-anarchism: A new direction for insurrection in the mental health system. *Annual Review of Interdisciplinary Justice Research*, 7, 232-257.

enlightenment, and something we may need to recover from and move past in order to live a manageable and viable life? Even more crucially, is there a way to find space between radical constructivist and abolitionist approaches to self-determination, and perspectives that value medicine and biomedical understandings of consciousness, without succumbing to centrism?

I respond to these questions by proposing the development of a new understanding of political engagement in the context of psychiatric abolition; namely a post-anarchist approach to the study of psychiatric power and resistance. Psychiatric post-anarchism is a theoretical approach meant to shift the focus for social change in mental health from macro projects concerning institutions, stakeholders, and governing agents to the micro-political realms. Following Saul Newman (2011, 2016), I imagine the ways in which a focus on praxis and the ‘here and now’ shapes our conceptions of radical politics and emancipatory endeavours. Rather than succumb to what I see as failures in classical anarchist thought and some critical/anti-psychiatry movements that position people as sovereign actors against the state, I argue that contemporary Mad Movements must be willing to constantly challenge their own ontological presuppositions when critiquing and mobilizing against the social forces that render some forms of understanding as mad. Since I have identified the positive successes of the Mad Movement in Chapter 2, it becomes necessary to interrogate how the movement can improve.

But of course, for psychiatric post-anarchism to survive as something more than mere polemics, I must first situate such a framework within the historical and present contexts and resistances that have shaped Western mental health systems, and then specify how an anarchist position remains both possible and useful today. It is to this task I now turn.

*Pitfalls and Triumphs of the Critical/Anti-Psychiatry Movements*

In rallying against the abuses of the psy complex, the ‘anti-psychiatry’ movement emerged in the 1960s, which Thomas Szasz (2010b) later clarified as meaning ‘anti-coercion’. While the scholars engaged in this counter-political movement generally sought to dismantle and eliminate psychiatry as an academic discipline and medical practice (Cooper, 2013; Guattari & Deleuze, 1996; Laing, 1960; Szasz, 2008), some, more than others, still saw value in treating mental illness.<sup>4</sup> Many of these people developed new ideas and investigative lenses that emphasized experiences with madness as a spiritual gift or potentiality that can teach us about (or how to transgress) the limitations of everyday consciousness (Deleuze & Guattari, 2009; Farber, 1993, 2013; Laing, 1967). Although still heavily under-researched, the recent emergence of mad studies in Canada vis-à-vis critical disability studies and some forms of narrative inquiry continues to challenge the master narratives of the psychiatric apparatus by positioning voluntary and involuntary users of healthcare systems as privileged authorities on their own state of being (Adame, 2014; Burstow, 2016; Cohen, 2008; Crossley & Crossley, 2001; Farber, 1993; Kirmayer et al., 2015; LeFrançois et al., 2016; McKenzie-Mohr & Lafrance, 2017; Steele, 2017).

While the anti-psychiatry movement is far from dead (see especially Burstow, 2015), it is imperative to acknowledge that its reputation has been tarnished and discredited due to the problematic and misleading ways in which its ideas were managed historically. Szasz, perhaps the most notorious and criticized pioneer of the psychiatric abolitionist movement,

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<sup>4</sup> It is important not to conflate terms such as madness, mental illness, insanity, and lunacy. Whereas mental illness implies the presence of a mental defect or disease of the mind, madness (to the spectator) is a liminal term referring informally to either a state of craziness/bizarre behaviour or very severe mental affliction. Insanity is a purely legal term describing a person whose mental state precludes them from being held criminally responsible for their actions. Therefore, rationality and insanity are defined through a relation of negative externality. The presence of rationality is the condition of impossibility for madness and vice versa. To be rational is to not be insane. To be insane is to not be rational.

mobilized the anti-psychiatry ideology to have people killed and criminalized by the state (Szasz, 2004), or deinstitutionalized without adequate community care and support (Novella, 2008; Schaler, 2004; Shek & Pietilä, 2016; Stroman, 2003). In his fifty years of writing, he worked tirelessly to dismiss widely and professionally established ideas about mental illness as symptomatic of disease and pathology, claiming that mental illness did not exist at all but rather constituted everyday problems of living which are part and parcel to the human condition (Szasz 1972; 1994). By calling into question psychiatrists' power to remove accused subjects from the punitive legal and penal apparatuses – which could sometimes spare them from the death penalty – Szasz insisted anti-psychiatry movements must buy into the moral-rationalist notion that all people are coherent enough to accept responsibility for their actions. It is hard to overstate the scorn and derision Szasz leveled at the discipline of psychiatry over his fifty years of writing. He believed people are tricked into believing they are ill, or in some cases clumsily accept such a label without any scepticism so they may more easily come to terms with their inner sufferings (see Szasz in Farber, 1993). The introduction of his masterwork *The Myth of Mental Illness* begins as follows: “Psychiatry is conventionally defined as a medical specialty concerned with the diagnosis and treatment of mental diseases. I submit that this definition, which is still widely accepted, places psychiatry in the company of alchemy and astrology and commits it to the category of pseudoscience” (Szasz, 1972, p. 1).

Trained as a physician, Szasz's definition of illness is fundamentally reliant on a homeostatic structuralism. The body, being an organism tending towards equilibrium in its function is ill when its structure manifests an abnormality. Szasz's position does not rule out the development of psychiatric symptoms *a fortiori*. It is rather that the conception of illness

refers to a malfunctioning organ. As the mind is not an organ it, therefore, cannot be ill. His definition of illness is by no means arbitrary. It is one he finds useful because it suits his staunch libertarianism. Szasz (1970, p. 299) is uncompromising in his belief that most of psychiatry is inherently coercive since should the necessity arise, a psychiatrist may be obligated to have their client involuntarily committed in a facility against their will: “The practice of ‘sane’ men incarcerating their ‘insane’ fellow men in ‘mental hospitals’ can be compared to that of white men enslaving black men. In short, I consider commitment a crime against humanity”. Szasz justifies his critique of psychiatric practice entirely on a utilitarian calculation. Consider the distinction he makes between the forcible confinement of a ‘criminal’ and that of a ‘psychotic’:

The principal purpose of imprisoning criminals is to protect the liberties of the law-abiding members of society. Since the individual subject to commitment is not considered a threat to liberty in the same way as the accused criminal is (if he were, he would be prosecuted), his removal from society cannot be justified on the same grounds. (Szasz 1970: 304)

From a critical criminological perspective such a view is incredibly problematic. There is a long history of imprisoning people who pose no threat to the liberty of others as Szasz himself is well aware considering his criticism of the criminalization of drugs (Szasz, 1992). Of course, this evidence alone does not invalidate his claims. Rather his view is problematic because it proposes a zero-sum binary wherein the removal of freedom from some must be justified in terms of the acquisition of freedom by others. Reasoning, as he does, requires Szasz to assert that ‘freedom’ exists outside of relations with others, that is, outside of relations of constraint. In striving for realism, Szasz committed himself to the ultimate form of idealism in political philosophy.

Michel Foucault (1975; 1988; 2006), whose politics were arguably much more discrete, contended that scientific and contemporary understandings of madness were generated by the very rational politics and truth regimes of which madness can, by definition, play no part. He showed, through his historical nominalism, that scientific practice for determining madness was not the result of the internal validity of the knowledge itself and its correlate in perception, but as a result of the historical *a priori* categories that determine the applicability of valid judgements. In his celebrated lecture “The Subject and Power,” Foucault (1983, p. 216) identifies the basic kernel of political action as “promot[ing] new forms of subjectivity through the refusal of this kind of individuality which has been imposed on us for several centuries,” namely by the state. Yet his transcendental structure, privileging of perception, and separation of knowledge from ontology — meaning only those things we perceive do we know and thus can we speak about as existing — renders such praxis all but meaninglessly radical. Foucault (1988) might have challenged the discourses of madness, specifically how they are the necessarily excluded element in western philosophy since Descartes, but he did not go far enough because he privileged the separation of knowledge from praxis while simultaneously putting forth an idealist ontology of the body. Madness nonetheless exists; it is just something that need not be dealt with in such austere fashions, as others continue to claim (Rose 1994, 1998, 2006b). While Foucault was intensely politically active in the early 1970s, his research practices have been largely politically ineffective because he lacked a way to incorporate the ‘ready-to-hand’ or proto-ontological foundation of sensation into an intelligible platform for activism. Anarchist Paul Feyerabend (1987: 6, 299) is very blunt about his feeling towards this type of scholarship:

Instead of providing guidance for personal and social choices they withdraw into their theoretical edifices and explain from there why things were as they were, are as they

are and will be as they will be...theoreticians are not that innocent. They are recommending analysis over and above understanding, and this even in domains dealing with human beings...without realising that a procedure whose main aim it is to get rid of all human elements is bound to lead to inhuman actions.

The theory of post-anarchist praxis I forward here is one that prefers not to view thinking with “cognitive priority over the conditions of their effective survival in the world” (Margolis, 1989, p. 377). The theory of praxis views cognitive behaviour not in the Foucaultian sense as a reflection on an external and unknowable world but rather as (re)productive and generative because it activates the latent potential of human beings. In other words, since people themselves produce truth rather than just dream of it, they are brought closer to universal forms of meaning.

In trying to explore both the potentials of madness and materialize them into institutional forms and practices, Gilles Deleuze and Félix Guattari (2009) approached madness as an expression of an existential impasse created through relationality and epistemologies of ‘becoming.’ Schizoanalysis is the inverse of engaging with a line of thinking that internalizes a pre-existing model.

What does schizoanalysis ask? Nothing more than a bit of a *relation to the outside*, a little real reality. And we claim the right to a radical laxity, a radical incompetence – the right to enter the analyst’s office and say it smells bad there. It reeks of the great death and the little ego [...] The task of schizoanalysis is that of learning what a subject’s desiring-machines are, how they work, with what syntheses, what bursts of energy in the machines, what constituent misfires, with what flows, what chains, and what becomings in each case. (Guattari & Deleuze, 1996: 88-92)

They promoted scholarly adventures that are expansive and seemingly *endless*: “live the field of the possible that is carried along by the assemblages of enunciation...throw[ing] [ourselves] into an analysis without knowing what [we] are going to find” (Guattari & Deleuze, 1996: 136). With no beginning or end in sight, the body without organs, or diluted substance of the interpellated subject, represents the “interbeing” of substance and production

– it is the point of rupture and also continuity in an apparatus where meaning unfolds, takes shape and interacts with other parts. Allow me to explain.

For Deleuze and Guattari (2009), biological, social, and political assemblages – which refer to the machinic substances and intensities that produce flows and operations, and establish connections between certain multiplicities – operate beyond the level of the individual human subject. Consider Delanda’s (2016) example of the warrior-horse-bow ensemble of the nomads. This assemblage “can become a component part of a large one, a nomad army, while its own components can also be treated as assemblages: the bow as an ensemble of a flexible arc, a string, and a projectile” (p. 4). Thus Deleuze and Guattari do not simply write about subjects, but engage in a form of collective, discursive writing that make critique possible (Usher, 2010). Because of this, reading them is difficult, but their point is to force readers to think outside of established modes of reason that become naturalized, hegemonic, and repressive. Take, for instance, their concept of the rhizome. Opposite to the tree of knowledge, which represents a secure, foundational knowledge with a logical hierarchy, the rhizome symbolizes non-hierarchical entry and exit points in data representation and interpretation, “which is opposed to arboreal conceptions that work with dualist categories and binary choices” (Usher, 2010, p. 70). Deleuze and Guattari (2005) are critical of views in the world that privilege master narratives of the Western Enlightenment, which tend to presuppose the inevitability of hierarchy and authority. Rhizomatic networks have unexpected eruptions where desire infiltrates logic in a constant state of movement and fluidity, connecting any point to any point while not necessarily being linked. The rhizome is a critique of all totalizing logics and systems that seek to explain circumstances, existences, experiences, and realities within a master code or framework.

The suppression of resistant practices still occurs however. Deleuze and Guattari (2005) describe how planes of organization work alongside the planes of consistency, trying to bring to a halt lines of flight (which I will soon conceptualize) and interrupt the movements of deterritorialization. Social forces and systems such as capitalism necessarily de-territorialize by destroying traditional social hierarchies, but at the same time, re-territorialize and reify new forms such as the state; it is in a constant process of collapsing and being restructured. The rhizome is made of “lines of flight”, which radically can be understood as a metaphor for everyday resistance that lead in a multitude of directions (Wood & Brown, 2010). Rhizomes are made up in the struggle between stabilizing (lines of consistency) and destabilizing (lines of flight) forces such as psychiatric power and resistance, and thus their vectors “connect and unify different practices and effects and by so doing establish hierarchies and fine relations between centre and periphery” (Usher, 2010, p. 71). Lines of consistency establish rules of organization, such as the way in which this dissertation is structured, while lines of flight disarticulate relations between and among practices and effects, breaking down unity and coherence. Lines of flight transgress codified and socially hegemonic practices and abnormal behaviours through various practices of discontinuity, disruption, or fracture, which overcome docility and uniform life, “changing forever the nature and significance of familiar histories and given situations as they interact along the way” (Wood & Brown, 2010, p. 519). Drawing on this concept, this dissertation explores what lines of flight, or continuous transformation, challenge and subvert psychiatric power (which is a line of consistency), or conform and remain within society’s coded flows.

The analytical chapters of this dissertation will represent lines of flight, as the narratives struggle to resist psychiatric discourses and power while still being enabled,

disentangled, and conformed by them. There is a ‘mental health’ reality but then there is also the reality of representation, which constitutes an interplay of forces which generate the regularities that classifications work to pick out (Duschinsky et al., 2015). Classificatory systems, such as mental illness, both hide and partially capture the subjugated reality of madness and spatio-temporal dynamisms that articulate living forms from within, as opposed to a pre-given essence or structure. When sequences of behaviour are simplified as unitary, Guattari (2011) cautions that scholarship ends up reproducing linear, objective causalities. A line of flight, rather, does not result in any comfort or protection, but allows free-flowing subjects to regain their milieu when danger appears; yet also live on the boundaries of exteriority, both with fragility and confidence (Deleuze & Guattari, 2005). Where there is reterritorialization, there will be deterritorialization, just as in the narratives presented here by mental health service users, we see both undichotomized constitutions of resistance, conformity, and struggle. The hope of such a concept enables the expansive possibilities of experimentation in the context of desiring-production, or in other words, “to keep enough of the organism for it to reform each dawn; and...to keep small supplies of significance and subjectification, if only to turn them against their own systems when the circumstances demand it” (Deleuze & Guattari, 2005, p. 178, as cited in Duschinsky et al., 2015, p. 184).

Lines of flight are also intersectional in that they coalesce the “co-constitutive forces of race, class, sex, gender, and nation” (Puar, 2012) and so on instead of problematically imposing mutually exclusive identity paradigms (Crenshaw, 1991). Intersectionality rejects the top-down ordering of oppression and holds that social divisions mutually construct and constrict each other (Keating, 2016). How dispositions unfold and take form within social movements is nuanced, unanticipated, unpredictable, unstructured and fluid to such a degree

that we cannot mistake subject positioning as a stable and fixed experience (Khasnabish, 2008). I found friction and assemblage between how activists represent themselves as subjects of political suppression and as relational figures who critically engage psychiatric power. There is no simple method available that exhaustively categorizes, defines and describes the participants' conflicting social struggles and lives, or "litany of disjunctions" (Deleuze & Guattari, 2009). In this research, the theoretical concepts that emerged in practice surfaced in messy ways, which supported Guattari's (1996) assertion that "nothing can unravel, by the sole magic of the transference, the real micropolitical conflicts in which the subject is imprisoned; no mystery, no hidden universe" (p. 52).

Also, many of the participants in this dissertation are racialized, which refers to the idea that "social structures, social ideologies and attitudes have historically become imbued with 'racial' meaning, that such meanings are contingent and contested, and that they are shaped by a multitude of other variables, economic, political, religious" (Small, 1994, p. 36). Black and minority ethnic communities are disproportionately represented in the mental health system, with statistics showing that in the UK, for example, they are three times more likely to be admitted to psychiatric care, 44% more likely to be compulsorily detained, more often diagnosed with schizophrenia than white service users, more likely to have police involvement in their admissions, and more often experience physical and chemical restraint (Keating, 2016, pp. 173-174). There are sparse examinations of race in the extant literature on madness (Gorman, 2013; Kanani, 2011), thus this analysis will at times try to unfold intersections of madness and race in order to provide a more nuanced understanding of the persistence of racial inequalities in the mental health system.

For Foucault (2006), agency (which I will conceptualize later in this chapter) is something that should be aspired to when resistance is needed, and which can be regained by playing games of truth.

...psychiatry said more or less: I will not pose the problem of truth with you who are mad, because I possess the truth myself in terms of my knowledge, on the basis of my categories, and if I have a power in relation to you, the mad person, it is because I possess this truth. At this point madness replied: If you claim to possess the truth once and for all in terms of an already fully constituted knowledge, well, for my part, I will install falsehood in myself. And so, when you handle my symptoms, when you are dealing with what you call illness, you will find yourself caught in a trap, for at the heart of my symptoms there will be this small kernel of night, of falsehood, through which I will confront you with the question of truth. Consequently, I won't deceive you when your knowledge is limited—that would be pure and simple simulation—but rather, if one day you want really to have a hold on me, you will have to accept the game of truth and falsehood that I offer you. (pp. 135-136)

Of course, not everyone believes destabilizing the forces of power within these institutions vis-à-vis “truth games” is the best way to venture forth in a critique of the establishment.

Critics of these post-structuralists such as Chomsky (1981) are more interested in getting the wheels of social justice moving and using whatever tools of social change the system allows to better change the unjust structures found within apparatuses such as psychiatry. The rationalistic thinkers Habermas (1983) and Mill (2005) would argue that the opening up of communication spaces that facilitate the democratic and free market exchange of ideas would also be a valuable way to enact social change. Further, as is the case with many critical ventures that “promise too much” (Bracken & Thomas, 1998, p. 17) and rush to production, some of the more macro experiments and institutional reforms that drew on these models of destabilization – such as asylums where mental health service users had some control over the function of the institution – succumbed to cooptation (Guattari, 1996). As emphasized in Chapter 2, any reforms that operate, at least in part, under the influence of the biomedical

model always seem to encounter this problem (Fennell, 1996; Foot, 2015; Lawton-Smith et al., 2008; Novella, 2008).

Foucault's passage, however, is important at shifting our attention to the value of micro-political struggle. My reconceptualization of psychiatric resistance is interested in the 'surplus' that enables praxis in the first place and privileges the autonomy of the subject without resting on beliefs in the possibilities of grand narratives and macro-forms of resistance. Asserting distance from institutions is not so much of a revolutionary procedure as it is an insurrection. As Newman (2016, p. 56, emphasis in original) sums it up within his post-anarchist frame, it is "a withdrawal from the game of power and counter-power altogether...[to] an *indifference* to power." Being indifferent to power is desirable because it asserts space from the very entity that creates friction and constantly collapses struggles – struggles that are vulnerable to failure because of a problematic faith in the public's capacity to obtain democratic enlightenment and widespread change through rational debate against the State (Dean, 2001; Steckle et al., 2019). Localised acts do not await revelation but rather reveal the capacities and potentialities of agential behaviour to challenge or support the status quo.

### *Psychiatric Post-Anarchism as a Desirable Future*

So what exactly is post-anarchism? Simply, it is the position that presupposes anarchy as an inherent condition of social order. Rather than viewing anarchy as the end result of a series of political actions, post-anarchist politics becomes the actualization of an always-already innate freedom (Newman, 2016). It should be clear enough that such a position necessitates a break with forms of political action that rely on either metaphysical conceptions of subjectivity or supreme moral or normative principles guiding praxis. Yet to

endorse such a position, I am presented with some problematic questions: particularly, is it possible to cross the aporia separating perspectival knowledge from legitimate truth? If so, on what *foundation* can such a truth be based?

Coming up with a theory to help frame this problem is crucial if I am to develop a new political praxis for psychiatric resistance, particularly one that situates itself in the anarchist tradition. However, given the present analytic suspicion towards meta-narratives (Newman, 2001), I have to be clear about what this foundation would look like. Woodcock (1962, p. 7) describes three essential components of any potential ‘anarchism’: first, it must be a criticism of existing society; second, it must have a view of a desirable future; and third, it must propose a way of transitioning from one to the other. Since I have already satisfied the ‘criticism of existing society’, it is with the latter two of Woodcock’s (1962) triad that I am now concerned.

Classical anarchist thought is typically criticized on the basis of its supposedly naïve or otherwise facile commitment to a utopian world in which hierarchical systems of authority are abolished. The negation of these hierarchical systems of authority, principally represented by the state and its “bodies of armed men” (Engels, 1981 [1942], p. 230), is popularly understood to be done in furtherance of a world marked by chaos, disruption, and destruction. In other words, anarchist thought is marked colloquially by *negation* and does not, and indeed cannot, put forth any *positive* conceptions of social order (Williams & Arrigo, 2001). The singular focus on negation often results in the anarchist being represented as a cynic. A very old but apt joke might help make this clear: a fellow goes into a restaurant and says to the waiter, “Coffee without cream, please.” The waiter replies, “Sorry, we’re out of cream. Could it be without milk instead?” Here the anarchist is that person more

concerned with the lack or absence of something and is therefore marginalizable as a scoffer or misanthropist (see Johnston & Johnston, 2017). My goal is to capture something more positive and life-affirming in anarchist negation.

But what sort of anarchism is even possible today? Nineteenth-century anarchists floundered as a consequence of their binary conceptual divisions that distinguished between natural and artificial authority and essential versus oppressed human nature; that is, the idea that ‘Man’ was possessive of an innate morality and rationality. For anarchists like Bakunin (1953), this hidden kernel of ‘Truth’ was simply oppressed by the existing power centres of society such as the Church and the State. His desirable future consequently was one in which anarchism goes beyond the limits of the Church and State to allow for innate human morality to actualize itself.

Rooting the position of resistance to forms of order imposed without animality, or otherwise material aspects of human subjectivity, was crucial to establishing a theoretically justifiable political position from which to oppose the Church and State. However, as Vaccaro (2013, p. 126) recently argued, the establishment of an ontological arché or “counter-foundation of being” in these forms of anarchistic thinking is problematic because it tends towards transcendental abstraction. Rather than engender a new form of order from within the inherent chaos that marks human social systems, these early anarchists succumbed to reformism by imposing another form of authority from without, that is, a substitution of ‘rational power’ for the ‘power of authority’ (Newman, 2001; Schürmann, 1987).

To incorporate post-modernism’s scepticism towards meta-narratives and sweeping claims into the development of an anarchist political position, I still have to accept that this

post-anarchism would be one that would abandon epistemological foundations in the legitimacy of science and rationality as master-discourses (see Hacking, 1983; Feyerabend, 1975), and ontological bases in the acceptance of an originary and primitive human nature. So to answer the earlier question in the negative: no, one can never cross the aporia separating perspectival knowledge from legitimate ‘Truth.’ Thus there is a need to revisit the issue of how aporia is represented.

What I need to do is perform a Žižekian move by assuming this difference between perspectival knowledge and legitimate truth has the fundamental structure of a Kantian antinomy. No longer can we reduce one side of the antinomy to the other by saying we either have one perspective from which to view the world or the naïve realist view that there ‘really is’ an ultimate truth that human finitude *prevents us* from accessing. Instead, we must assert the difference as irreducible, and “conceive the point of radical critique not as a certain determinate position as opposed to another position, but as the irreducible gap between the positions themselves” (Žižek, 2006, p. 201). This position opens up a new domain that traverses the binary between real/illusory by undermining its distinctiveness. The importance of the Žižekian move here is that the ontological status of human being is marked by a terrifying excess or non-symbolizable kernel that thwarts any attempt to define it, but still remains inherent to the conditions of *being and becoming* human.

This is why psychiatric post-anarchism must be one that relinquishes classical anarchism’s *a priori* assumption of an innately moral-rational human subject. Anarchy as a political position is not a *telos* or a *means* to an end but the *actualization* of an always-already innate human freedom possessed by virtue of its own excess. This type of freedom must not be misunderstood as the classical anarchist or liberal political economic sort. People

are not “born free and everywhere in chains” (Rousseau, 1998, p. 49). However, and contra the assertions of social constructionist arguments, neither are we completely discursively constructed subjects. As such, ontological post-anarchism locates itself somewhere amidst the anarchist-cum-liberal understanding of a free and autonomous individual at the centre of history and the social constructivist position of a totally discursively interpellated subject.

*Psychiatric Post-Anarchism: How Is It New and How Do We Transition?*

Perhaps the ‘post’ in psychiatric post-anarchism does not in-and-of-itself connote something ‘new.’ The ‘post’ is nothing more than an exercise in re-signifying anarchism in light of the knowledge that the ontological preconditions of anarchism — the moral-rational human subject — have never actually existed. Of course, I do not just want to preserve a specific lineage to the past, but want to revitalize anarchist ideas in ways that were never intended. That is, by using the Žižekian conception of the subject as always-already both inside and outside relations of power alongside Newman’s (2016) anarchism, which does not presuppose an innate human agency, I mobilize a new political position from which to critique the coercive psychiatric apparatus.

The newness described here is a praxis for psychiatric resistance that, as done in the past, raises concerns over how our world can be such that psychiatric practice appears so intelligible and holds true at all times for the person to whom such perceptions are normal. Yet under these conditions of power, psychiatric post-anarchism operates on a platform that carefully and seriously weighs concerns for recovery and the unpredictable circumstances that accompany mental illness, against the risks and harms of enduring psychiatric coercion, violence, institutionalization, and normalization. I am forwarding a political position that

values the legitimization of multiple forms of resistance and even conformity, and accepts that different outcomes will work for different people.

What I believe is the biggest question here, and one that is of most relevance to critical criminologists of this age, is: to mobilize such a political mode of engagement, must we not abandon the historical tug of war that exists between reformists, abolitionists, and supporters of the establishment? Does the merger between abolitionist and post-anarchist thinking lie in its approach to struggle? In thinking about Woodcock's (1962) criterion of transition, if the goal of psychiatric post-anarchism is to generate peace *and* insurgency, it follows that re-coding and re-mapping the intensities of political movements is imperative to asserting space from power, authority, and battles from within that escalate tensions and constrict so many social movements (Gavrielides, 2008; Nagle, 2016; Piché, 2016).

The only true position for an emancipatory political critique of psychiatric power is through the recognition of cognition as something that itself has presuppositions — presuppositions that require a fundamental gap in the individuals themselves as a result of their existence as relational beings. Madness is a type of relation to an uncertainty (science), and its conditions of validity are historico-specific. Yet even if we do not identify as mad, madness is our neighbour and thus a fundamental component of us at all times, which means that we can always *mobilize it*. The grounds for political emancipation must be rooted in a conception that (1) suspends the idealist assertion of perception as the root of knowledge and (2) is effective because it grounds its conception of agency in an ontological 'surplus' or 'excess,' that, like the obverse of a mirror, is present but un-symbolizable within the frame.

This model, therefore, is one that works hard to (but never can) relinquish personal authorities, theoretical cynicisms, and inner fascisms (Deleuze & Guattari, 2009) that have

spearheaded dogmas trying to define the ‘best practices’ of political struggle. There has to be some acceptance of the agency of others to resist or accept the system within the means that are available to them, even if this means circulating (to some extent) the hidden or macro agendas of political and institutional stakeholders. An example of a relevant movement embodying these principles is Psychiatric Survivors of Ottawa (2017), which is a community organization of peers who use their “lived experiences with the mental health system to support one another in moving towards [their] full potential.” Driven by the values of self-determination and respect for the people’s varying identities and relationships with the mental health system, they provide alternative recovery and wellness programs (e.g., art, spiritual outlets, music, movies, exercise, games, community transitions), as well as a diverse range of peer and family support networks and workshops.

From a post-anarchist position that starts with a non-acceptance of coercive power in order to open up “space[s] of contingency and freedom rather than following a set pattern of anarchism” (Newman, 2016, p. 15), the success of a critical psychiatric post-anarchism movement cannot be measured by its capacity to abolish the entire (macro) psychiatric apparatus. Let us evaluate it instead by its capacity to promote autonomy, knowledge production, self-determination, alliance building and growth, and heal people in the ‘here and now’ by transforming the immediate circumstances and relationships of actors entangled within the system. It would be easy to advance Szasz’s old abolition by suggesting, as the anarchists long before us did, we remove the state altogether instead of merely severing the link between the state and psychiatry. But psychiatric post-anarchism can do more by focusing its concentration on the present moment forms of action and insurrection instead of single-issue revolutionary projects.

There is no problem with utopian imaginaries, and, indeed, a certain utopian impulse is central to all radical politics in the sense that it punctures the limits of our current reality. However, what guarantees are there that the realization of the stateless society — to the extent that this is a possibility — would not bring with it its own unforeseen coercions?... What is central for me in anarchism is the idea of autonomous thinking and acting which transforms contemporary social spaces in the present sense, but which is at the same time contingent and indeterminate in the sense of not being subject to predetermined logics and goals. This does not mean that anarchism should not have ethical principles or be impassioned by certain ideals — but rather, that it should not, and perhaps any longer *cannot*, see itself as a specific programme of revolution and political organization. (Newman, 2016, pp. 12–13, emphasis in original)

It should be unsurprising to my readers that this perspective, like others (Kirmayer et al., 2015), sees the enactment of alliances between activists, scholars, and caregivers as a strategy to discover new forms of organization, genres of freedom, and techniques for bargaining with authorities. Negotiation is not a permanent commitment, nor does it have to compromise the subject's values through an acceptance of the sanist discourses that were built on gendered, heteronormative, neoliberal, racialized, and colonial foundations of reality (Burstow et al., 2014; Deleuze & Guattari, 2009; Drescher, 2013; Johnston & Kilty, 2015; Joseph, 2014; McKenzie & Bhui, 2007; Raz, 2013; Russell, 1995; Whitaker & Cosgrove, 2015; Ypinazar et al., 2007). But the ideas and beliefs we cannot tolerate or surrender to sometimes come from people who, like us, make mistakes and still seek to improve the conditions of living.

### *On Responsibility, Autonomy, Resistance, and Agency*

It is now important to further conceptualize the terms I have raised. For Nietzsche (2014), who was a mighty inspiration for Foucault, responsibility is severed from any understanding of a 'will' or 'consciousness' and manifests itself as a result of the bodily dispositions of individuals which are themselves affected by their circumstances. Writing during the same era as Freud, Nietzsche believes that responsibility is conditioned based on

systems of discipline that train individuals to respond to stimuli in particular ways. To Nietzsche, at the start, we are all just bundles of libidinal forces seeking pleasure and avoiding pain. When we transgress, our bodily energies recoil upon us and breed into us certain dispositions and ethical relations of self-to-self and self to others. Responsibility is the product of this development. Nietzsche criticizes morals, values, and juridical notions of responsibility for their contractual models rather than showing their developmental character, and he roots the originating force of this development in the bodily energies of the individuals. Nietzsche thus severs the conscience, understood as the awareness of the difference between right and wrong, from the juridico-moral accountability code. The conscience is not determined by material forces, moral universalism, or a totalitarian government enforcing an array of norms.

This framework problematizes the legal idea of backward-looking accountability linked with the “moral idea of accountability that focuses on the agent’s forward-looking conscious intention” (Diprose, 2009, p. 116). Diprose’s critique of the juridico-moral idea of personal-responsibility raises an important question; namely, how can we conceptualize responsibility without fostering determinism (in demanding continuity between past and future)? She points out some of the problems with this tendency:

Under such conditions of a *failure of political responsibility* there is a tendency either to fall into step with this revised code of conduct such that personal responsibility (in the juridical sense of accountability or duty) seems to vanish, or public life descends into a blame game and responsibility (duty and blame) fall disproportionately toward women, particular racial and ethnic groups, the socially disadvantaged, and the dispossessed...what happens to the capacity for personal responsibility, and the normative basis of conscience judgment, and conduct, when the laws and moral norms we supposedly embody seem to be undermined by a government that we assume is responsible for keeping them in place? (Diprose, 2009, pp. 117-118)

Diprose (2009) conceptualizes responsibility beyond the freedom determinism debate, which signifies a relation between the self and juridico-moral code that is excessive, self-critical, and transformative of norms, and thus leaves people open to an undetermined future that is a condition of conscience. Nietzsche (2012) asserts that the force of forgetting, rather than memory and self-consciousness, constitutes human existence, and the juridico-moral code of accountability and law counters this force by attaching to some intensity, thus in some sense, joining forces with the force of forgetting. In other words, one owns the past in the present but under the compulsion of an undetermined future. Hence, “the temporal structure of the promise and of accountability assumes the ability to commit the self to a *particular* future and, through a selective memory, to recoup in that future a past self, word, or deed that is now present” (Diprose, 2009, p. 122).

The point of all this is to position responsibility in a way that does not rest on obedience to the law and norms one inherits instead of choosing. Nietzsche (2014) is critical of responsibility insofar as it rests on the premise of free will. Nature is not freely chosen but inherited, and therefore we cannot predict the future or stake a claim to it. But although we cannot choose the future, we can transform our inheritance of it and open up new possibilities. Genuine self and political responsibility becomes more about developing a critical politics that resists the imposition of futures on everyone rather than viewing individuals as sovereign, calculating, irresponsible subjects.

And what does this discussion have to do with power relations and resistance? Consider Deleuze’s (1983) take on Nietzsche when he identifies that power is not what the will wants, but the one that wants in the will. Hence we “will never find the sense of something (of a human, a biological or even a physical phenomenon) if we do not know the

force which appropriates the thing, which exploits it, which takes possession of it or is expressed in it” (Deleuze, 1983, p. 3). Even acts of power, domination, and subjugation result in new interpretations, which can be mobilized to reveal a particular complexity about the forces which are already in possession of the object. Every force is related to another force; every will is necessarily exercised on another will and is not an involuntary process; this is the principle of Nietzsche’s philosophy of nature. When there is a will to command or obey, there is a creation of hierarchy (dominant and dominated force), which Deleuze (1983) identifies as the problem inherent in nature: “life struggled with another kind of life” (p. 8), or more simply, power with and alongside resistance.

Of course, certain forms of resistance do little more than serve to reinforce the system of injunctions that come to define themselves over and against transgression. So transgression in some instances serve as the libidinal support for mechanisms of sovereign, juridical, and negative power. Consider Foucault’s (1977) writings on ‘counter-conduct’ in *Security, Territory, and Population*. This is an important moment in Foucault’s history of liberal governmentality as protestant resistances in the 17<sup>th</sup> and 18<sup>th</sup> century are seminal in weakening the political power of the church while simultaneously increasing the hold of religion on the collective minds of the population. The object of government moves away from the economy of souls and towards the government of men and their relations with religion being one of men’s qualities rather than a more encompassing object of government. It becomes actively written into the genealogy of liberalism that subjects should be seen as reflexive and resistant beings who have the capacity to refuse to accept modes of government. This dynamic between ruler and ruled creates new mechanisms for exploitation, as it allows for governments to engage in game theory, playing one side against the other.

Yet, counter-conduct can also meaningfully affect political administration and lead to real change and not mere populist outbursts. It is case specific. Resistance is the art of counter-conduct: a desire not to be governed in that way, by those people. We can relentlessly question: “By whom do we consent to be directed or conducted? How do we want to be conducted? Towards what end do we want to be led?” (Foucault, 1977, p. 197). The basic point here is that with modern forms of power, resistance comes to be the antecedent of power: there is no power without resistance.

However, Foucault is primarily critiquing a model of power that is rooted in juridical conceptions of right and authority. This relies on a social and political ontology of binary dualism that Foucault contends no longer holds after the 18<sup>th</sup> century. It relies on what he calls a circular ontology of political power; the idea that a ruler has a divine right and the ability to carry out sovereign power without any connection to the regularities of the collective lives of those being ruled. If political power comes to be seen as rooted in the domain of civil society (which in this conception loses autonomy), then modern social life is no longer fragmented along the lines of a political dualism (sovereign/subject), but political power is infused within the domain of collective life. Political space has acquired a very ‘flat’ character and has to rely on the libidinal energies of individuals, groups, and organizations to serve as its point of anchorage. So, if power is not localized within political/juridical institutions but should, as a first principle, be seen as diffused within social life, so must also be resistance. There can be no general theory of resistance or encompassing definition: there can be local or particular ones based on a time or place (as Newman clearly contends).

I could critique Foucault for offering no model of resistance beyond guerilla warfare, mindlessly attacking forms of power and hoping for the best. But I think Foucault’s point is

simply that resistance cannot be seen as the transcendental valorization of an innate human or subjective capacity. The idea that humans have an ability to be self-reflexive, self-regulating, and questioning arises in history at a point in time for Foucault and its arrival on the political stage reformulates the dynamics of political space.

However, what Foucault never really considers is that in Kant, there might be reason to suggest that people continue to exist as non-knowing beings. Foucault's model of human agency is based on the idea of a knowing, interested subject; there is no consideration of what Žižek (2006) calls practical solipsism or that people can act without really knowing why. Not just that people are lacking full information since that is inevitable, but that people might be doing things they are unaware of. In Žižekian terms, unaware-actions have performed a socially-synthetic function. They create a social bond based on mutual understanding of propriety.

On the whole, the more civilized human beings are, the more they are actors. They adopt the illusion of affection, of respect for others, of modesty, and of unselfishness without deceiving anyone at all, because it is understood by everyone that nothing is meant sincerely by this...In order to save virtue, or at least lead the human being to it, nature has wisely implanted in him the tendency to willingly allow himself to be deceived. (Žižek, 2014, p. 59)

Here, the basic gesture or tendencies of humanity are to act in ways they do not understand. This does not valorize the inner worldliness or ascetic life nor is it a submission to external legal codes. Agency is more performative. This explication will be demonstrated through the varying acts of agency I and my participants encountered during our lines of flight with madness. In madness, we lose some element of control, so I argue we are also agential in a performative, less-intended manner. This idea of a social conditioned unconscious is the basic thrust of Žižek's psychoanalysis; that people are marked by incompleteness or loss and are constantly dealing with this in ways that are structurally variable and have tendencies

among different populations. This alters the structure of resistance. Resistance is not about making calculations that vary over time and space, but it is about acknowledging the tendencies of systems that you cannot understand; acting in ways that are positive and agential, but not necessarily directed.

To return to the point of *Bartleby*, a conception of psychiatric resistance of this kind still relies on having to choose to refuse the choice: “I would prefer not to”. We have to target the system that forces choice by finding its own condition of impossibility. We simultaneously choose and do not, and do not fully understand why. This would also seemingly open up the Foucauldian understanding of resistance to include the ‘mad’ population. Who are mad people if not the people who cannot choose? Who cannot make informed decisions? Whose behaviours place them outside the normative structures? But if resistance is based on an ontology of human being that valorizes the performative dimensions, then self-knowledge is neither a pre-requisite for agential social behaviour nor praxical resistance. So do not expect the participants in this dissertation to know (in the realist sense of the term) in the throws of madness (even if their post-hoc narrativizations deceive), but expect them to resist, and expect the meaning of that resistance to be mobilized into a framework of political responsibility.

### *What Does the Future Look Like?*

I should emphasize that it is not my intention in this dissertation to imply I am always/already critical of those who take a firm and unwavering stand against the formal mental system. The mental health service users you will hear from in this work, including the author, all take a different position in terms of their criticism, resistance, conformity, and disengagement with the Canadian mental health system. But some people have just simply

had enough of psychiatry *because of* what psychiatry has done to them or their loved ones. Madwomen in the Attic (2017), a grassroots feminist support group in coalition with the Network Against Coercive Psychiatry (n.d), continues to publicize how women “have been victimized, traumatized, harmed, shamed, or otherwise affected negatively by the psychiatric industry at large...[that] misuse[s] mental health treatment as a form of social control, policing, or bullying into submission.” Yet by making post-anarchism the departure point for action rather than imagining a society without power relations, we turn more to a Mad Movement that questions all the ways in which power is accepted, admissible, inevitable, and distributed — including the ones we create and promulgate. Sometimes the greatest prisons we face are ontological: in the everyday, inner struggles for power and control that strike our sense of being must first be overcome before we can imagine how massive networks of social control can be meaningfully changed. As I learned in my own mental health journey, engaging these struggles, remissions, and relapses is a life battle. One of the contributions of this dissertation is to interrogate if such a “micro-political transformation of the self in relation to power” (Newman, 2016, p. 54) can help mental health service users and people positioned within the Mad Movement become more aware and critical of the political consequences that could arise from sweeping macro change or destruction that some ancestors of the critical psychiatry movement toyed with.

The answer to finding a balance between treatment and coercion, to organizing mental wellness between domination, power, and coercion, I argue, begins with challenging the macro discourses of madness through micro-political resistances. Put simply, if bigger and broader changes are going to ensue, then the smaller changes have to happen first. These ripples can take effect by listening to, and engaging the stories of a few mental health service

users. Other strategies might include prioritizing raising our children in caring (not corrective) environments (see Chapter 7), teach them how to appreciate (and not dismiss) others' emotions, creativity, and different capacities for learning in schools, and encourage one another to develop active listening skills and befriend those in distress (Burstow, 2017). Burstow emphasizes that when these humanistic values are adopted, services will unfold in ways that do not always give precedence to psychiatric expertise but rather emphasize community participation and responsibility — whereby conflict management and “people’s welfare [are] everyone’s concern” (Burstow, 2017, p. 37). This vision requires a distance from apathetic leanings that are also guilty to power, and which allow psychiatry to remain as a thinly critiqued institution.

Something as simple as re-directing day-to-day power relations between mental health service users and doctors through our voices and struggles could certainly be counted by the Mad Movement as a valid form of resistance to the myths, stigmas, and labels that circulate throughout our institutions. Intervoice (2018) (The International Network for Training, Education and Research into Hearing Voices) and the Hearing Voices Movement have gained prominent ground in Europe to challenge the assertion that hearing voices is always a sign of mental illness. They educate psychiatric professionals, the public, and people with mental health concerns that not everyone who hears voices is overwhelmed. Some are able to draw on alternative strategies to manage their voices, while others actually need their voices to help construct a deeper understanding of their life experiences (Blackman, 2001; Jenkins, 2015; Jenkins & Barrett, 2004).

If the Mad Movement is tenacious and empathetic in its approach, psychiatric apparatuses will have more incentive and will to learn from its dogmas, and help vulnerable

populations in the present moment under conditions that trust and respect the autonomy and expertise of service users. As found in the historic anarchist traditions, this perspective is still unapologetic in its idealism. I sustain my confidence that the day will come when mental health service users are afforded the capacity to be sceptical of the psychiatrists' solutions and cures, refuse them at times, and negotiate all the available options so that they are comfortable with what tries to make them better, especially within spaces that are less violent and stigmatizing than many psychiatric hospitals. After all, an insurrection that is impossible to defeat is one that refuses defeat, but to do so it must remain in motion and travel in unpredictable directions, unafraid of its intersections, divergences, and oppositions (Khasnabish, 2008).

To be clear, my goal in this dissertation is not to adopt a self-righteous relativist approach to understanding and resisting mental illness: "far from appearing as merely a repressive or negative force, psychiatry can often direct its interventions at willing subjects" and those who believe the expertise will help them (Scull, 1991, p. 169). However, the coercive application of psychiatric treatment to people who do not support it, or cannot communicate their lack of support, walks a thin ethical line and therefore must be continuously be interrogated (Burstow, 2016). While these are points of sensitivities to be aware of as we embark on this insurgency, they are not, as Burstow (2013, p. 85) remarks, "reason to dispense with these words, nor reason to tone them down, nor even reason to bypass the ones not yet adopted by the community as a whole." Make no mistake about it, we will never be able to understand everything about the mind and body, be it our own or others'. Yet the myriad ways in which others speak about the mind and resist discourse can all work together to demystify understandings of madness that put our dignity in peril. For

the sake of both moving forward and starting over, we have to believe in our capacity to create something new and better. We cannot do this with eyes that refuse to gaze at the unbearable pains of affliction, stigma, and suppression, and ears that ignore the meaningful sounds of irrationality and uncertainty found in the stories of people. While the insanity of reason and stability decays, the sense and glory of madness await our discovery.

## **CHAPTER 4: NARRATIVE METHODOLOGY**

The psychiatric apparatus' inability to coherently capture the complexity and messiness of madness provides the starting point of this research. There exists the need to better identify and theorize the dimensions and temporal shifts that contribute to the good, bad, and ugly of madness if we are to improve our understandings of, and reactions to it. To trust, mobilize, and listen to the voices of those who encounter madness or live unbearably inside institutions of social control has never been more urgent. My post-anarchist praxis and narrative framework of inquiry offers a platform for service users to story and mobilize their experiences with the psy apparatus as well as their sense of self in relation to this apparatus, in ways that resist, accept, endure, complicate, and add knowledge to dominant ideological and medical narratives. Our stories contribute to the growing but small mad studies movement in ways that nuance and/or coalesce the ideologies and emergent forms of activism. Before the storytelling can begin, this chapter is dedicated to fleshing out the framework upon which this research draws from and engages.

### *What is Narrative Inquiry?*

A narrative tells a short or long story about something meaningful and significant in a person's life (Butler-Kisber, 2010); it is a way of knowing, thinking, understanding, and speaking that is embodied, integrating physical, social, and psychological dimensions of comprehension and experience (Bruner, 1986). Big stories tend to be autobiographical and are used to analyze identity, while small stories, that is, the stories we tell in passing in our everyday interactions, tell us how narrative is "performed and accomplishes particular tasks, including identity" (Bamberg, 2004, p. 367, cited in Phoenix, 2008, p. 64). Narrative inquiry is a fusion of interdisciplinary and disciplinary approaches to research, methods, and analytic

lenses that gravitate around an interest in “biographical particulars as narrated by the ones who live them” (Chase, 2005, p. 651).

Both the sociological and psychological narrative traditions idealize storytelling as an “important activity because narratives help people to organize their experiences into meaningful episodes that call upon cultural modes of reasoning and representation” (Fraser, 2004, p. 180). From a post-structural position, people narrate stories to others in order to convey their emotions, beliefs about the world, and the blurred ways of knowing that bring about messy accounts of lived experience, and to “make sense of the epiphanies or existential turning points in their lives” (Denzin, 1997, p. xvii). Denzin (1997, p. xvii) clarifies what he means by “messy”: “messy texts are many cited, open-ended, they refuse theoretical closure, and they do not indulge in abstract analytical theorising. They make the writer a part of the writing project”. Narrative researchers carefully consider the power of words, and how their accumulation can render visible hidden meanings and transgressive, counter forms of knowledge.

The narrative turn in social sciences is broadly characterized as a movement from the locus of objectivity and post-positivist realism to that of subjectivity and interpretative constructions and analyses of meaning (Clandinin, 2007; Pinnegar & Daynes, 2007). With an emphasis on uncovering *and* building particular and deeper meanings of social phenomena, narrative inquiry in general distances itself from generalizable approaches to methodology such as quantitative research, which looks for mathematical relationships in empirical observations and data (Guba & Lincoln, 2005), or grounded theory, whereby researchers try to build up rather than dig down theoretical propositions through the analysis of their data (Charmaz, 2000). Whereas sociological approaches to narrative inquiry tend to emphasize

the relational contexts that guide how stories are produced, made meaningful, express identities, as well as reinforce and contest dominant social practices in our societies (Doucet & Mauthner, 2008; Cohen, 2008; Fraser, 2004; Polletta et al., 2011; Somers, 1994), narrative approaches blossoming out of psychology usually focus on how the self is created by individual thought and language processes (Bruner, 2004). What follows below is a description of the four major turns in narrative inquiry, or categorizations that help us identify where researchers and disciplines have located themselves in relation to narrative methodology and knowledge making. While these borders remain porous, they trace well the critiques and epistemological tensions that have pushed narrative modes of inquiry to influence, in some way, most of the social sciences.

### *The Narratives Turns in Social Sciences*

Pinnegar and Daynes (2007, p. 3) describe four methodological narrative turns in the social sciences: “the attention to relationships among participants, the move to words as data, the focus on the particular, and the recognition of blurred genres of knowing”. Before elaborating on each one, I will mention that what all four narrative transitions hold in common is that they study stories and descriptions of a series of events, and embrace the idea that the story is perhaps the most fundamental and telling account of human experience.

The first methodological narrative turn, which is characterized as “a movement away from a position of objectivity defined from the positivistic, realist perspective toward a research perspective focused on interpretation and the understanding of meaning” (Pinnegar & Daynes, 2007, p. 9), acknowledges that research is an encounter where relationships between researchers and participants will change both parties, as well as shift and blur any established identity categories and power dynamics that might have been present before the

research began (see Belur, 2014; Beuthin, 2014; Johnston, 2016; Walby, 2010). Here there is a recognition that social interactions are rarely static but embedded in context, culture, and histories; thus to decontextualize findings requires a great deal of caution in order to speak to the experiential nuances and differences of social phenomena.

The second narrative turn promulgated the paradigm wars (see Given, 2017) and rejected the modernist trend towards statistics so that reliability can be met, or put differently, “asserting that anyone experiencing a phenomenon would label it with a similar, hopefully identical, number or in the same way” (Pinnegar & Daynes (2007, p. 15) for the purposes of verifiable replication. Narrative inquiry as both a method and phenomena of study is driven by the same assumptions of qualitative research more broadly. Whereas quantitative approaches generally value prediction and control of the research setting, qualitative and narrative researchers are interested in understanding their participants. Experience is the inductive departure point of a narrative research design, question, and practice.

Narrative inquiry begins in experience as expressed in lived and told stories. The method and the inquiry always have experiential starting points that are informed by and intertwined with theoretical literature that informs either the methodology or an understanding of the experiences with which the inquirer began. In essence, narrative inquiry involves the reconstruction of a person’s experience in relationship both to the other and to a social milieu. (Pinnegar & Daynes, 2007, p. 5)

This form of what Bruner (1986) labels paradigmatic knowing endeavours to know the ‘actual’ and universal conditions and aspects of experience, in contrast to narrative knowing which seeks to understand the ‘possible’. Narrative methodologies in sociology especially oppose the “bourgeois” (Hartung, 1945), “bogus” (Young, 2011), and erroneous promise (Kuhn, 1970) that research, as a scientific endeavour, can be (to some extent) a neutral, generalizable, unbiased, atemporal, minimally value-laden activity (Guba & Lincoln, 2005). Narrative knowing replaces numbers as data with words because numbers and statistics draw

on a restricted language, whereas stories speak with more power and wonder to the accounts of kindness, hopefulness, resistances and relations to inequality, marginalization, and oppression. Like any methodological representation, statistics are social constructions (Wylie, 2009, p. 316), yet the sterility in how numbers are often presented in research provides researcher with few avenues to explore “the coherence of the reports or the consistency of expression or the nuances of language that suggest integrity” (Pinnegar & Daynes 2007, p. 20). Words, on the other hand, give us that opportunity, especially since not all social phenomena are quantifiable nor reducible to the forces functioning on their constituting elements (Turner, 2006).

This is not to say that using numbers to illuminate empirical realities is flawed or wrong, however narrative inquiry questions if numbers actually meet the goals of positivism as originally laid out by Comte (1875), which is to formulate universal and generic properties of the social world and laws about their dynamic properties (Sebok, 1995; Turner, 2006). Certainly, this tool can achieve these implications for mathematics and physics, but it is a cumbersome task to use statistics across all the human sciences and social sciences in ways that speak fully to the complexity of the social world. And still, narrative inquiry, like most qualitative models that value case studies and attention to detail in participants’ voices, is still subject to evaluative post-positivist questions surrounding the merit, trustworthiness, and rigor of the research (Flyvbjerg, 2006). This is where narrative approaches to methodology differ, namely in deciding: Who owns a story? What counts as stories? What makes a story ‘good’? What are the most appropriate and descriptive modes of analysis researchers can draw on to make sense of, and disseminate the results? What happens when narratives compete? Lastly, what are the reasons for choosing particular stories (Lafrance & McKenzie-

Mohr, 2014)?

In moving from the general to the particular, the third narrative turn holds that there is more to be gained in understanding accounts as subjective, and the accumulation of this knowledge will never be neat and tidy to the extent that it can make universal claims about experience without any tension. This idea connects closely to the sociological imaginative project of Mills (2000) and the symbolic interactionism tradition, in that subjectivities can be seen as gateways to identifying how personal troubles equate to broader social issues. Subjectivities that are produced through stories do not add up together to give us a neat portrait of reality (Denzin, 1997). Instead, this blurred way of knowing (the fourth turn) provides us with a deeper and more comprehensive picture of the innumerable social forces at work that create inequality and injustice, with an emphasis that there are multiple ways of understanding experience. Thus interpretations and possible solutions to social problems will bloom out of particular cultural contexts (Pinnegar & Daynes, 2007). The difficulty still present in this model (and the fourth narrative turn in general) is that it assumes that a person, even if fragmented, messy, and multi-voiced is always stable enough in terms of cognitive function that they can be storied, or storytell. Truth, then, becomes a competition. Whatever stories they do share become rendered as fiction because their bodies and minds are seen as lesser than those labeled as able-bodied. It is the goal of this dissertation to take the stories of people who experience mental illness, in all their complexity and digression, and position them on the spectrum on truth to add to the body of knowledge in the sociology of mental health.

### *Porous Disciplinary Boundaries*

Drawing on Chase (2005), Butler-Kisber (2010) identifies five major approaches to

narrative inquiry across disciplines. While narrative psychologists tend to focus on how stories affect people's individual lives (I elaborate on this more in the next section), narrative sociologists, on the other hand, explore how the processes of storytelling shape the construction of identities as well as our relationship between the events of lived experience and the articulation and interpretation of these activities in a narrative (Clandinin, 2007; Doucet & Mauthner, 2008). This way of accounting for experience differs from other sociologists who concentrate explicitly on intensive interviewing practices to investigate how people draw on language conventions to make meaning and sense of their lives. Within the field of anthropology, several anthropologists have merged life history approaches to interviewing with critical ethnographic methods to co-construct explanations of events and cultural practices. Lastly, autoethnographers who use narrative dialogue and the study of the self—sometimes in collaboration with other voices (Ellis, 2000; Sparkes, 1996; Wall, 2006)—aim to render intelligible their complex autobiographical experiences. Distinct from psychological trends, narrative sociologists interested in exploring their self or the self of others do not treat their interpretations as “disengaged from an obdurate reality” *alongside* the understanding that the veracity of narratives should also not be “dealt with by attempting to find objective indicators, uninfluenced by subjective interpretations” (Ezzy, 1998, p. 170).

The key difference in how these approaches vary based on disciplinary frames relates to researchers' perspectives on how identities become known and constituted; namely what roles, performances, and stories researchers prioritize and legitimize in the creation of meanings. Does identity come from 'within'? Is it always produced relationally? Can observers demarcate an identity without intervention from the participant? How do all of these critical questions resonate and intersect throughout the process of storytelling and

meaning-making? Narrative psychology that is grounded in the positivist paradigm “assumes a unitary, rational narrator, a coherence of identity, and a transparency of meanings between interview and interviewee” (Rogers, 2007, p. 102), and so from this perspective it is appropriate for researchers to ask participants about facts, events, and meanings in sensitive ways that do not second-guess or take for granted the storyteller’s point of view. Bruner (2004), a psychologist, argued that the construction of selfhood through storytelling involves an unending process of mastering how to meet our needs that are dependent on the situations and circumstances we encounter.

In contrast, narrative sociologists, anthropologists, and some psychologists (see Weine, 1999) working more explicitly from a social constructivist lens reject naturalist, individually-driven views of the self and believe that the self and meanings are created in large part through sociality. The narrator, listener, and narrative take shape through their social context as well as the “multiple truths and shifting identity positions” (Rogers, 2007, p. 102) common to social relations. Narratives as a social production place importance on the researcher to be self-reflective about the research process and their role in the mutual creation of meaning.

Post-structural narrative researchers on the other hand assume stories have been produced through social discourses as opposed to simply changing in accordance with social contexts (Denzin, 1997). For them, narratives are a process by which a narrator constructs a reality, and readers and listeners frame that reality based on their understanding of the story (Marcus, 1994). Post-structuralism is a response to (and not anti) structuralism. Scholars in the structuralist approach to knowledge study systems by analyzing their structures, with the assumption that every system has a definite structure. They try to identify the universal,

general laws by which those structures function (Combs & Freedman, 2012). Post-structural scholars seek to classify finer and finer levels of complex systems that have ambiguities and paradoxes (Combs & Freedman, 2012). My post-anarchist praxis I developed encourages me to focus on the local and particular aspects of stories, rather than their generalizable meanings. To answer my research questions, I will focus on how mental health stories are valued in terms of how they embody exceptions and uniqueness, rather than categories per se. I will locate our agential capacities in the narratives to showcase the very specific and minute details that demonstrate our autonomy and capacities for self-determination in the mental health system.

Although described simply, this process of storying is not tangible to the extent that a narrative can be interpreted in a singular way because no categories of identity are stable; thus post-structural narratives will speak to the messiness and multiplicity of possible meanings, sometimes to the point that both the speaker or listener do not recognize the seemingly infinite implications and nuances (Rogers, 2007). While post-structural narratives—which are the ones this dissertation will engage—join “the personal, the biographical, with the political, the social” (Denzin, 1997, p. 200) and swing back and forth between voice, interpretation, and description, they should still favour emotionality in the stories shared in order to stimulate social change and critique (Cohen, 2008). Emotions, especially when some of them become labeled as mad or deviant (Thoits, 2012), have a tendency to not count as truth when challenged by competing rationalities. Emotions, however, matter because they are a way of knowing, and often a trigger point to understanding a phenomenon (Spencer et al., 2012). When we feel strong emotions towards something, there is meaning to be found.

Narratives are inextricably emotionally structured, since emotions are fundamentally relevant to social life. We learn about emotions through the unfolding sequences in stories (De Sousa, 1980), and thus our own re-telling of these events will at some point capture emotionality. Temporality and subjective representations of these emotions relay their significance and configure the emotional experience of listening to a narrative (Kleres, 2011). We cannot fully understand the emotions unless there is some consideration of its history (Nussbaum, 2003). Hence, the narratives presented in this dissertation will seek to grapple with those early emotional moments in the lives of mental health service users that help ground the many contexts that shape the production of their story.

### *Storytelling as a Research Method*

Narrative interviewing is an active process (and often far less structured) in which participants and researchers engage in a co-construction of meanings and memories that gains access to the complex past, “the told and untold, and the remembered and forgotten” (Gemignani 2014, p. 127). Fraser (2004) identifies how narrative interviewing helps the researcher respond to different communication styles, avoids turning the interview into an extracting exercise, builds trust, provides participants with freedom in how they respond to and ask questions, and lastly, helps researchers account for and make sense of the politics involved in making knowledge. Like much qualitative research, the goal of narrative interviewing is not to be generalizable, but reveal deeper meanings, biographies, and small and big stories that provide context to identities, all of which can stem from a small number of encounters (Anderson & Kirkpatrick, 2016; Bernhard, 2015). The narrative interview setting is one of many social sites where stories are shared and interpreted for the purposes of

recognizing our commonalities and differences with others, validating our existence, revealing and constructing our sense of self, and restoring order and value in our lives.

Storytelling is in our blood. We are the storytelling species. Stories were once the center of community life. We are recognizing more readily now that there is something of the gods and goddesses inside us, in the stories we tell of our own lives. Life storytelling gives us direction, validates our own experience, restores value to living, and strengthens community bonds. (Atkinson, 2002, p. 122).

Despite these advantages to narrative research designs, narrative researchers doing critical work have to strike a sensitive balance between analyzing the stories in ways that maintain the authenticity of the participants' voices, while still presenting the research as a contribution to the broader movements aimed at bettering (self) recovery programs and desisting coercive institutional practices. It might go without saying that what authenticity means in the context of a mental health user is difficult to pinpoint (hence the contribution of this project), especially from a perspective that accepts that meanings and stories are built relationally. Researchers are bound to have their own preconceptions about mental health (critical and/or not) and therefore may not relay the precise meanings that were intended by their participants. Interjections of reflexivity throughout the research design can soothe this tension (Doucet & Mauthner, 2008). In particular, narrative research designs can implement autoethnographic components in the form of short story writing, reflexive intervention, poetry, art, or vignettes to render intelligible their complex autobiographical experiences (Ellis & Bochner, 2000; Sparkes, 1996; Wall, 2006). Vividly depicting my experiences with the psy complex will give readers a strong idea why I am located in the project the way I am, and they can use those illustrations to draw their own conclusions about the stories that are shared.

Of course, some experiences are messy or “radically non-narratable” (Butler, 2001, p. 59, as cited in Stone & Kokanovic 2016, p. 104), especially in cases when serious mental illness can deny people the opportunity to author their life stories in ways that are coherent to both the narrator and listener, and preserve or renew identity (Baldwin, 2005; Carless & Douglas, 2008; Larrabee et al., 2003). Stories that deal with trauma are especially difficult to retell.

Where the meaning of one’s life is disrupted, what words then can be found? What story can be told? For isn’t a story, from the ordinary person’s perspective, a meaningful telling or retelling of a coherent event or series of events that thus shows the listener a slice of the teller’s life and experience? But how does one say the story of political torture, of sexual assault, of wartime atrocity, of abrupt and untimely loss, when one commonality of trauma experience is the feeling of a chaos of seemingly unutterable experiences collapsing into that “wordless nothing”? (Larrabee et al., 2003, p. 354)

The ableist assumption that storytelling is the purest form of meaning-making has not been resolved since Bruner (1986) articulated the position; however researchers in critical disability studies have recently turned to the idea that narratives (not limited to storytelling, but also encompassing performative, artistic and autoethnographic designs) can assist us in understanding the complexities of the social world of people who are not identified as able-bodied and able-minded (Smith & Sparkes, 2008). Doucet and Mauthner’s (2008) perspective is that stories involving great despair, madness, and trauma are still told anyway, even if incoherent, and since stories are all that we have, it follows that meaning from them should not be called into question by discourses of irrationality and rationality.

It is important to add that the social scientist is deeply embedded in the processes that are being observed and written about. Plummer (1995) illustrates this point in his examination of the social aspects of people’s sexual stories that are usually taken up with individual, medical, and clinical discourses. He asks many sociological questions that beckon

researchers to critically take up their own positionality with respect to the telling of stories, and critically examine what is also not being said and why. Stories are not just living texts but comprise of social actions and performances embedded in social worlds, and thus it is our job to uncover and render intelligible those mysteries and the “real active, embodied, impassioned lives” that make them up (Plummer, 1995, p. 170), even when the stories share very trivial, visceral, and dark occurrences. Stories, too, have audiences who may react to the text with passion, using the narratives for guidance or as a place to find their own life. Other times, readers may respond with indifference, “hearing so lightly what others say so intensely” (Plummer, 1995, p. 21). It is my hope that the stories shared in this dissertation, difficult as some are to bear and believe in all their pain and stigma, will be transformed into political accounts that do justice to the mental health system, and call for ways to improve and rectify it.

To return to the discussion about mental health stories, even though it is unfeasible to do a phenomenology of any mind other than the one belonging to the phenomenologist, this does not create a post-modern conundrum that might pigeonhole us into believing we can only speak about the self. What we can do is a post hoc phenomenology of how others *speak about* the mind and mental processes (Kirmayer, 2000; Kirmayer et al., 2015). The limitation is that we are never analyzing the ‘here and now’ unless we are willing to confront the frontlines of madness, which carries its own distinct concerns for ethics. Storytelling, from this perspective, does not favour the modernist assumption that holds that language is an accurate and reliable link to the “clearly” and “unambiguously” demarcated boundaries between the objective (real) and subjective (mental) world “out there” (Freedman & Combs, 1996, p. 28). Rather, it engages with the postmodern idea that the only worlds we can know

are the ones we share interactively through language because language constitutes our truths and beliefs. Narratives cannot be delineated as a gateway to accessing pre-existing truths about the mind.

This ambiguous form of Kantian realism takes the position that there are universal truths and a world “out there”—what Lacan (1977) refers to as “the real”—however the impossibility of knowing universal representations of truth means that such a world might as well not exist. As articulated in Chapter 3, Žižek (2006) responds to this divisibility by arguing that even though the chasm between the objective and subjective world is irreducible and therefore inaccessible, we can still affect it vicariously through fiction, language, narrative, and so forth. Stories about life shape “the real”, and so we must interrogate its effects to reveal other conditions of ontological possibility. No matter what, the most complex autobiography will hide more than it discloses just as its interpretation will never be completely ‘true’, but what narratives do reveal are potentialities of how people “can resist their dictates and find support in subcultures that are living different stories” (Freedman & Combs, 1996, p. 33). Language, after all, is an instrument of power that shapes the production of discourse (Foucault, 1988). If the discourses of society decide what knowledge is true, proper and moral, then those who control discourse will inevitably control knowledge. From this angle, mental health narratives reflect our agency and capacities as actors to re-story the fallible dialectic around madness, which get reproduced by the polite, ordered, and moral society as concretely known and knowable. Mental health narratives can embody either resistance or a conformity that at the very least is drawn under the dynamic and ongoing conditions of consent. While most of the participants in this study were coherent and reflexive about their mental health journeys, one participant mentioned during our talk

how his story was about 20% complete. Partial knowledge, however, is still knowledge, and thus can be treated and mobilized as truthful.

### *Research Design*

#### *Interviews*

This study was approved by Carleton University's Research Ethics Board-A (CUREB-A, Project, #108479). I conducted unstructured, narrative interviews with ten individuals who identified as having recovered (or partially recovered) from a serious mental condition or problem. The interviews lasted between 50 minutes and 2.25 hours, exclusive of taking short breaks. Seven of them were held in a private study room on campus that could not be overheard by other people, while the remaining three, at the request of the participants, were held at a public coffee shop and fast-food location. Before commencing the interviews, all of the participants signed an informed consent form outlining the project details, risks, and sensitive nature of the study. Participants were compensated with a \$20 Tim Horton's (coffee shop) gift card for their time, and this was advertised on the recruitment materials. Seven of the participants were recruited from posters I placed in various locations on two university campuses in Ottawa, Canada. The other three participants were recruited purposively; two being good friends of mine, and the other being somewhat of a public figure in my community who does community-based mental health advocacy work. The interviews were confidential, and nine out of ten of the participants' names were replaced with a pseudonym of my choosing. One participant did insist that I use his actual first name and the name of his mental health project in this study. I explained to him the risks of this violating his confidentiality, and gave him four months to tell me if he changed his mind (September,

2018). I also provided him with a digital copy of his transcript to review and use for his own purposes.

### *Participants*

The participants' ages ranged from 20-35 years old. Four participants identified as women, and six were men. Six of the participants were born in parts of Canada, while the other four were born in other parts of the world. Five participants were people of colour, while the other five were white. Nine out of ten participants had come into contact with the mental health system, with three experiencing hospitalization (one for Bipolar disorder [involuntary] and one for suicidal ideation and attempts [voluntary]), one for Eating Disorder [voluntary]), and one recovered without any assistance from the formal mental health system. One person, however, only accessed counselling services for a couple of sessions before making the decision to discontinue because of financial worries. Another participant who was experiencing psychotic symptoms did reach out to psychiatric emergency and requested hospitalization, but was turned down because his issues were 'determined' to be the result of his poor socio-economic status. Seven of the participants accessed counselling services with a certified counsellor or psychologist over the course of their mental health journey, and six engaged in psychiatric outpatient care and took medications (including the three who were hospitalized). Services were primarily accessed across Canada in four major cities: Ottawa, Toronto, Montreal, and Sudbury.

Five participants accepted a formal diagnosis and were treated with medications, with two being Bi-Polar, one experiencing clinical Depression and Anxiety, one experiencing Depression and an Eating Disorder, and another who experienced psychosis, self-injury, and suicidal ideation. Another participant was loosely and eventually told he was 'probably'

Bipolar, but did not fully identify this way despite taking some sedative medication to relax his symptoms (Seroquel). The other two participants diagnosed with Bipolar were treated with anti-psychotics (Lithium and Risperidone), with one still currently taking treatment and the other has since discontinued. The person diagnosed with Depression and Anxiety has taken a variety of anti-depressants for several years. Another participant was told by psychologists she has symptoms of Depression, Anxiety, and Post-Traumatic Stress Disorder, but did not meet the criteria to obtain a formal diagnosis, so she never received psychiatric treatment or medications for these problems. One participant who identified as having a severe stress disorder during childhood and adolescence, but did not receive psychiatric care. The participant who did not access any mental health services identified as enduring great despair from childhood and adolescent bullying because of his stutter. Finally, three participants experienced suicidal ideation, two of whom these problems surfaced on more than one occasion.

### *Coding and Analysis*

I transcribed all the interviews myself and listened to them several times to get a feel for the narratives and see how they could be positioned in relation to each other and my own story. I made some field notes and mental notes after each interview to start building initial impressions of the themes, as well as track my own reactions. Approximately four months was spent with the data to then start building the broader narratives. Participants were offered at the outset of the study their transcripts to review and possibly de-identify themes or quotations, but none of the participants provided feedback on the actual transcripts (Funk et al. 2018). One participant though did have a discussion with me about our interview and offered more content to help with the analysis of his words, which I used in Chapter 6.

While the goal of narrative interviewing and analysis is to speak with participants rather than about them (Frank, 1995, 2012)—and indeed my own experience in the mental health system bolstered this rapport—analysis still requires that participants become the object of inquiry. Themes emerged inductively in the coding process, meaning I looked for similarities in the data and then created categories to try and bridge some of the narratives together in analytical sections (Smith & Sparkes, 2012). The primary themes and sub-themes that emerged in the coding process included agency, disengagement, spirituality, resistance, labelling, resiliency, institutionalization, family disjuncture, school pain, advice, activism, psy-agent failure, and subjectification. I examined and shared the stories as a whole, rather than in parts and snippets (Holstein & Gubrium, 2012) because breaking the narratives into parts and combining them with other stories ran the risk of complicating what are already very complex ordeals that diverge from one another quite often.

Mental health narratives are also rhizomatic (see Khasnabish, 2008) so they can be difficult to code with a great deal of structure and intersection. While I began the interviews by asking how participants' mental health journeys began, the narratives sprouted into many unanticipated and unpredictable directions, and moved back and forth, for example, between stories of child history and surreal moments of pain. The stories shared here are not always linear, but I have organized parts of the story to add clarity, and share each participant's accounts one by one (see Farber, 1993) in order to do full justice to their meanings. As Frank (2012, p. 37) notes, the commitment of narrative analysis "is not to summarize *findings*—an undialogical word, with its implication of ending the conversation and taking a position apart from and above it—but rather to open continuing possibilities of listening and of responding to what is heard". Thus I focused mostly on sense-making processes and accounts in small

and big stories that constructed emotions, worldviews, mental health characters or events, and how these tales illuminated the ways in which psychiatric power is resisted, governed, and conformed to in wider societal contexts (Phoenix, 2018).

### *Locating the Self and Doing Autoethnography*

Autoethnography is an approach to research and writing that systematically analyzes the self and personal experiences in order to understand broader cultural experiences, systems of powers, and wider political and social meanings (Ellis et al., 2011).

Autoethnography was inspired by the post-modern crisis of confidence in the social sciences to produce facts and truths out of grand and master narratives (Kuhn, 1970; Lyotard, 1991). Autobiography is generally seen as the source of the self rather than its expression or creative invention (Freeman, 2007). Autoethnography combines characteristics of autobiography, as authors retroactively and selectively write about past experiences. Autoethnographies can focus on single events, while autobiography is the fuller study of a person's life history. Most writers of this tradition tend to write about remembered moments and epiphanies that are thought to have significantly shaped the trajectory of a person's life (Denzin, 1989; Zaner, 2004), or "times of existential crises that forced a person to attend to and analyze lived experience" (Ellis, 2011).

Since I write about my experiences with the mental health system (which shaped my life greatly) and other events in my past, and position some of them in relation to my participants' experiences, this dissertation is located at the intersection of autoethnography and autobiography, or more concretely, my stories and the stories belonging to my participants. The reflexivity I engage falls within the radical humanism paradigm, whereby reflexivity becomes "the struggle to become aware of and combat the social forces which

alienate and dehumanize the person” (Holland, 1999, p. 473). Analytically, I use reflexivity throughout the chapters that follow as a brief intervention where I locate myself in relation to others, and discuss the divergences and similarities I had to confront. The conciseness of my reflexive interventions is to ensure that I do not break up the narratives being communicated by the participants, and thus make their story about myself.

By accommodating and recognizing the impact that degrees of subjectivity, emotionality, and evocative personal experiences have on the research process (Harding, 2004), autoethnography can deepen our concerns for social justice and empathies for marginalized populations (Ellis & Bochner, 2000, 2006). Doing so requires that our experiences demonstrate to readers how they might experience similar epiphanies or connect with the cultures being illustrated that traditional research tends to overlook (Ellis et al., 2011). Most people in the world, at some point or another, experience a serious mental health issue or know someone in their personal network who has tried to navigate it. Since few academic studies explore first-hand encounters with the mental health system and psychosis (Burstow, 2016; Stone, 2006), Chapter 5 will contribute to the small body of service user-centred literature by examining emotionality and surrealness during and after mental distress, tracing the feelings and sentiments that occur alongside recovery, and discussing how these experiences are connected to wider systems of psychiatric power, oppression, and institutionalization.

As Marshall (2004) and others (Phillips & Earle, 2010; Winkler, 2018) argue, doing first-person research involves a number of assumptions and dilemmas; namely a stable and coherent self, questions over whether evocative ethnography is better than an analytical one, concerns that confessional tales are a practice of self-aggrandizement and indulgence rather

than thick rich self-reflection, and an understanding that no biography or auto-ethnographic narrative is ever complete (or always coherent) as the whole mind can never be reported. Still, autobiography and autoethnography in narrative inquiry, especially those that illustrate poetic and creative dimensions, can become scientific knowledge if it is deemed sufficiently truthful (Freeman, 2002, 2003, 2004). That being said, my thick rich descriptions of the most memorable, heavy-laden, and impactful events are both subjective and subject to interpretation. In response, some authors have tried to strike a balance between an evocative and analytical approach that complicates and critically analyzes larger cultural discourses and stigmas surrounding mental health, and allows readers to access the emotions and bodily disjunctures that accompanied my mental health experience (Anderson, 2006; Denzin, 1997; Jubas & Seidel, 2016; Rennels & Purnell, 2017; Stanley, 2015; Williams & Kamal Jauhari bin Zaini, 2014). However, I still intend this research to have generalizable meanings. This is why my approach to autoethnography is more analytical than it is evocative. While the point of evocative autoethnography is to bring readers into the lived experience of storytellers, who are often at the margins of society, in order to promote empathy, understanding, and to develop community (Bochner and Ellis 2016), the narratives presented in analytic autoethnography seek to make some raw and sometimes widespread conclusions about the impact of institutional power, relations, and regimes of truth (Anderson 2006). My approach to this dissertation is more traditional because the point of my claims is to go beyond the story itself and service, rather, a wider critique of the mental health system.

To achieve this in my own autoethnographic account, I drew on Marshall's (2004) evaluative criteria for quality autoethnographic notes. While drafting and polishing my story, I aimed to write accounts that were "alive, rich, and multi-faceted but also succinct...[so as

to] bring experience to the reader sufficiently well and not draw them into too much [unnecessary] detail” (Marshall, 2004, p. 310). Throughout the revision processes, I, with the help of my committee, challenged my story to be appropriate to my research question. Specifically, I asked, does my story critically speak to resistance and illness in the mental health system? Does it invite readers to reflect, challenge and give lively feedback on my account? Do I strike a balance between attention on the self, my agency, and interaction between other agents of the mental health system, family members, and other spectators? All in all, do I tell a systemic story that “honours and keeps alive multiple connections” (Marshall, 2004, p. 314) and brings into focus a critique of the mental health system that is evidenced and not polemical?

When writing my accounts, I drew on an ethnographic narrative form that is both poetic and story-like, and uses character development and plot description to illustrate points of tension that are difficult to put into words in everyday conversation (Inckle, 2010). I draw on some visual art, poems, photos, songs and song lyrics, diary entries, and letters to help fully engage the senses of my body and mind as I lived psychotically and recovered from it. These supplementary, creative interventions in the self-narrative helps me reflect on the emotional dissonance that occurs when my perceptions and representations became at odds with, or conformed to those belonging to medical experts who are in a position of authority and trust (Davidson & Smith, 2009; Davidson, 2016). I explore what happens when I both fail to appreciate and willingly accept my treatment, and what are the implications of telling a different story about my embodied self that, unlike many medical expert narratives, makes room for emotions and experiences that cannot be measured or rendered totally coherent. Visual narrative inquiry as a whole “is an intentional, reflective, active human process in

which researchers...explore and make meaning of experience both visually and narratively...[in] an undivided continuous transaction or interaction...that includes not only thought but also feeling, doing, suffering, handling, and perceiving” (Bach, 2007, p. 281). Thus after telling my story in Chapter 5, I use these experiences as an entry point to analyze other conversations I had with fellow service users.

### *Ethical Considerations and Reflections*

Most of us know that the repercussions of many forms of mental illness can be permanently damaging, life altering, and greatly traumatic to family members, communities, and those afflicted. Therefore the participants I spoke with about their journey with mental health issues constituted a vulnerable group that could encounter emotional and psychological harm in the study. Recalling sometimes frightening, depressing, painful, or frustrating experiences while trying to recover from mental illness, or resisting the stigma and labelling that comes with such identification from others, can be a cumbersome task for participants (Dickson-Swift et al., 2009), and could have included those who might have been confident from the outset that they would experience no harm while sharing their stories with me. To overcome this major risk, and with the help of Carleton’s Research Ethics Board, I developed a number of mitigation strategies. Although none exercised this right, I offered participants the opportunity to bring a friend or support person with them during the interview. I did not ask many questions about their specific symptoms to avoid triggering, but rather let them guide the interview. I informed them in the consent form and in person of their right to terminate the interview whenever they wanted to, and told them that they did not have to answer any questions they did not wish to. In the recruitment flyers, I asked for participants who identified as recovered or well into their recovery to help avoid the risk of

interviewing someone in a less stable state. The friends I interviewed in this study also identified this way. I brought to each interview a list of local counselling and emergency mental health services to refer the participants to if they experienced distress. While I am critical of the psychiatric apparatus, I have not positioned myself as anti-psy, and should others want professional help (or really need it in an emergency), I did not allow or believe my politics and beliefs should have any impact over that decision.

Fortunately, this need never arose and all of the participants were very forthcoming and generally experienced the questions with ease and comfort. These were people who had many years to reflect on their mental health journey, in fact, more than the author of this study. None of the participants experienced distress during the interviews, and one appeared as having experienced some emotional discomfort, but it did not result in crying, emotional outbursts, or a request to stop the interview. I saw him on several occasions following our interview, and he appeared to be doing quite well. In terms of the participants' 'stability' during the interviews, nine of the ten participants appeared to me in a very healthy frame of mind and grip on reality, while it was clear that the remaining participant experienced a different reality than most people. He claimed to experience visions, create imaginary figures, and use these gifts to create stories and art. While he was happy, made sense, and was easy to talk to, I referred him to a local counselling service during our interview, and asked him to follow up with me sometime about his artistic endeavours. To date, he has not done so.

It became apparent very quickly during the research process that writing about my own mental health struggles and listening to others' stories was harder on me than it might have been for my participants to tell me their stories. Writing about my battle with psychosis

and recovery is traumatic. Just thinking about it causes me to suffer. There is no life ahead of me where I will not relive from time to time its horror and nightmare. I accept that the worst of madness is a permanent haunt, those who survive it are chased by this ghost, and when it backs off, it is usually accompanied by the promise of return. Family members caught up in my struggle were left in dismay: they had to reconcile in their recovery how affliction can strike someone's reality in such a way that the mind is turned inside out and destroys everything in its path. How do we pick up the pieces and move on? There is much literature on writing about trauma, doing sensitive research, and different techniques to make things more comfortable on the researcher (Baird & Jenkins, 2003; Bober & Regehr, 2006; Coles & Mudaly, 2010; Connolly & Reilly, 2007; Dickson-Swift et al., 2009; Fincham et al., 2008; Slattery & Goodman, 2009), but in my case none of it mattered. There is no easy way confronting the darkest period of one's life and turning it into a dissertation. Making sense of my greatest tragedy and victory started the day I became psychotic, and will live on in the words and memories I choose to surrender.

I mentioned on my ethics application concerns that I could be triggered when writing stories about mental health journey. The truth is, for my condition, I can become triggered any day of the calendar year. Hearing music that I used to listen to when I was paranoid will remind me of the delusions I engaged and fought against. I am occasionally brought back to a state of psychosis when I dream; I have visceral nightmares of being chased down by the world, fighting against immanent death. Simple words or phrases by strangers can spark suspicion in my mind. Images like an 'x' on a construction worker's vest can create a caution in my mind to tread lightly and watch out. I have to live this way. All that said, I am a coherent person. Most people do not see the scars left on my brain. If they knew how I

live(d), most people would not believe the sense of control I have developed over these delusions, and my capacity to keep myself contained to the Real.

I do not imply that I always have full control, or that doing a PhD has been easy. Despite my strength as a scholar, I have internal weaknesses and mental limits that grind my progress and grip on reality to a halt; limits that I do not become aware of it until it is too late. In November of 2017, during my proposal defence, I broke down in tears when asked a question about what I think a family narrative is. The pain I put my wife and parents through hit me like a ton of bricks, and the realization that my body can lose control terrified me. This was at the same time I was recording and piecing together tracks for my album about my journey with psychosis. Approximately three months later in early March, 2018, after what had been a remission of four years from brief psychotic disorder and about three years without the need of psychotropic medication, I experienced symptoms of paranoia and delusions all over again. Whatever was holding together my mind in this period fell off the radar, and the world started to become against me all over again. Did the triggers cause it? Was it pathology creeping its way back in the lived world? Who knows? But the difference, this time, was that I got help right away and went back on medication, and within a couple of months I felt more like myself, in the strangest sense of the word. Myself, to me, means that I wake up unafraid, and that I can shrug off the occasional imaginaries that come over my presence. It is during this time I write this dissertation. I am medicated, but I am protected from the darkness that could lurk in my thoughts as I tell you about madness. Tears stain some of these pages, but this is something that must be done for the sake of obtaining closure from this dark time in my life, helping my own family members recover from the pain they experienced in trying to help me get better, making better sense of an experience that has

puzzled and created in me a great sense of uncertainty over what reality is and how it can change, and doing justice to the stories of madness that are far more complex and ineffable than the established medical systems dictates. My story will be incomplete: there are darkneses and embarrassments I am too fragile to share with others. But rest assured, I will show you madness. Now, I will show you madness in a handful of dust.

**CHAPTER 5: OUT OF MY MIND AND BACK IN AGAIN: AN AUTOETHNOGRAPHY  
OF MY MENTAL HEALTH JOURNEY**

*For the waves of death encompassed me,  
the torrents of destruction assailed me;  
the cords of Sheol entangled me;  
the snares of death confronted me.  
In my distress I called upon the LORD;  
To my God I called.  
From his temple he heard my voice,  
and my cry came to his ears.  
(2 Samuel 21: 5-7)*

*Prelude*

The hole in my head is starting to spill. A torch of lightning pours over my flesh and sets my head on fire. My spirit pushes against my bones and my eyes turn silent, my ears fall apart to the voices. Every minute I could be no more. Somewhere I see a clock and the minutiae of time bleed over the great parts of the machine, and I am stuck under its swarm. I pull hard on my leg and I cry out for mercy. I am losing control over my thoughts, something else is thinking on my behalf. I have taken the drug of madness and I am like a figment of your darkest imagination. This is hell. I fall further down into the valley of death, kicking and screaming, I try to crawl upwards in the belly of the vacuum. I am pushed and pulled in liminal directions, I see a future here; I hear the past's ghosts, foreshadowing my collapse. Is there some way out in the sight of the toad? I wander towards from a distance. The thought of bullets race past me every second. I am at war, fighting something that barely exists. And its hands are dark, its eyes are thunder, its shadow is merciless.

Let me live, O' God, another day, and I will tell you what I saw. I will surrender my vulnerability from the chaos that trails me, and show them the dark corridors and serpentine upon which I pass. People may think I'm insane and that is no lie. But I am not alone, and in this madness, I have found a better truth.

## *The Lead Up to Madness*

Terror struck me in the Fall of 2013: a nightmare that lasted many months, and which accelerated in intensity as the sun passed to and forth. In September of 2012, I had started a Ph.D. in Sociology on the west coast of Canada, and I knew in four short months that I would not survive the duration of the program. The people there were toxic, embittered, confused, burnt out, and unwilling to change. I was an angry, passionate young man who erred on the side of principle, and in my own fury, I had made it my mission not to go down without a fight. Over the course of the year, I had many conflicts with others; some matters trivial and others very personal. This was no place to pursue research, but it was the choice I made, and I was determined to follow through with the commitment after having moved across the country with my fiancée. With very little in terms of an emotional support system, since many of my friends had moved on elsewhere and my family resided on the other side of the country, I went through much of my struggle alone and isolated. My mental health was slipping. I became very depressed, cynical, and infuriated. To cope, I used cannabis and escaped into whatever sounds I could invent on my guitars (Johnston, 2013a/b). Eventually, the summer came. I somehow managed to pass all of my courses with an A-. I had grown a bond and solidarity with other peers going through the same toxicity, and I had something to look forward to: my wedding in August of 2013. While this remains one of the best days of my life, it was, in many ways, the calm before a great storm I would later escape within an inch of my life.

I forgot about everything during our honeymoon. I loved everyone who attended the ceremony, some of whom I would eventually come to hate. The bliss of oak trees scattered across the land and historical dimensions of time, peace by the sparkling pristine lakes, gentle

canoe trips, dreams by the mountains, rollercoaster thrills and the corporeal experience of true love. This was life. I let go of everything for that week.

When I came back to what I had left behind so temporarily, I was disgruntled and vulnerable. The next phases of criticism and unhealthy work relationships triggered me into a rage. I stopped showing up to classes. I started to become paranoid of the many authority figures in my life, who seemed intent on bringing me to heel. And to boot, I was set to have shoulder surgery in October for repeated dislocations, which intensified my fear and worries. Leading up to the surgery, I started hearing voices. I believed there were messages in the music I both played and listened to. The surgery was successful but it was painful. I was prescribed tramacet for the pain relief, and I took every last pill. While my physical pain eventually diminished, this period marked my entry into another reality, and one that I will describe in a prose accompanied by the artistic materials, a picture, diary entries, doctor letters, notes, and poems I salvaged from this nightmare and the recovery period that followed. I use this chapter to document my interactions with the mental health system, both good and bad, and to help make sense of an experience that permanently shaped my life and those around me. I begin the story by describing an event where I became lost and paranoid in the city where I resided.

### *A Day of Paranoid Travels*

The bus door flies open and I look straight into the driver's eyes. He has no smile, he stares at me as he waits. And I know he wants to take me to my end. I take one step on the ramp, and I sprint backwards and run away from him. I will go elsewhere, today.

I am lost. It is raining and I am getting cold. My feet are getting soaked. It's November. I go from street to street, the men in my head point me to the next turn, and I take

it. "Follow this street. Now turn here". I hang on to their every word. It is the only thing I can trust now, the physical realm has turned evil. I see a car parked by an apartment building, seated in it is a young man. "Travel with him," the voices urge me. I open his passenger door and get in. He is wearing a cast and texting on his phone. He looks at me in dismay and anger and curses at me, telling me to get out of the car. "What are you doing? Get the fuck out of my car!" I am puzzled, is this not what I was supposed to do? I listen to him and continue on my travels.

I am too afraid to look at my phone. It will tell me the wrong thing, the secret services have a wire on them. So I just follow the voices. I approach a growling dog, I ask him where I should go. He barks back at me, I say I don't understand. He barks at me again and an instinct overwhelms me to follow the path to my left. I was here before, an hour ago, but I see a basketball net. This is a sign. I sprint up to it and go for an air dunk and I am successful. I see another net. I am being challenged, but I am determined. I managed in one fell swoop to touch the rim, and I laugh at the competing voices judging my jump.

I have no idea where I am. I come to a hospital. It is starting to get dark. I am told a helicopter will be waiting for me on the landing pad, ready to take me to a new life, a new destiny. It doesn't show up. I am not concerned about security, they know what I am doing. Because the whole world is watching this event from a screen. From cameras inside my own body. From far away. I circle the landing pad and throw my hands in the air. Oh how long will this go on!?! But now it is time to go. I leave the hospital. I have a feeling it is close to my apartment but I cannot find it. Am I still in the same city? Was I transferred elsewhere overnight? The voices continue to lead me elsewhere.

Soaking wet I ask a woman I pass by for help. She just looks at me. I pass by a man who is talking on a cell phone and wearing a Toronto Blue Jays baseball cap. I used to watch a lot of baseball. Surely this is a message to me to call for help. My wife is at work, so I try my mother. I explain to her the circumstances. She is confused. She asks me why I can't just use my GPS to find my way back, and I tell her I can't get on the bus with "those people". Now I suspect she is against me. She, too, wants to lead me to a certain death. I fight this perception as I talk to her, but it is difficult. I try to take a cab back home. I call one and I think it comes but I can't see and it looks like a dark van. I am afraid of it, and I do not take it. Finally I use the remaining life on my phone to activate its GPS, and I find my way home. The path is clear now. The good forces have battled to take control of my phone. I get home, draw up a bath and lay there. Genevieve comes home and asks me if I am alright. My mother had called her and told her something isn't right. I fight the voices in my head and I tell her everything is fine. I drift off into nightmare and insomnia, voices waking me up every minute, and my hungry cat swatting me for food. He is becoming less and less real. I am caught in a chasm of voices, I cannot sleep and I have little perception of what you see:

Figure 1: "Chasms of Voices", Recorded November 12, 2017 (Available: <https://www.youtube.com/watch?v=TGlGc2sV6qY>)

I feel like this: Anxious, heart ripping itself out of my eye sockets to dark whispers, to lonely solitude and check-ins every five seconds. The voices are calling me to glory, calling me to Hell, warning me of troubles, prophesying nightmares propelling my delusions, altering my sense of being, building characters in my mind, implanting them on the faces around me, controlling my movements, controlling my glances, everything around me is the work of these voices. One after another, I feel no relief, I must live in this nightmare. The

sounds are a creep, treading lightly and consistently until I am strangled by their grip. All day and night, they taunt me.

Figure 2: “One After Another”, Recorded September 30, 2013 (Available: <https://www.youtube.com/watch?v=TGIgc2sV6qY>)

*Time Stops Passing: Haunt and the Everyday*

I go on like this for weeks. After Genevieve leaves for work every morning, I close all the blinds around me. I set out a row of cups on the kitchen counter for my protection when they barge through the door. I search for the cameras in the room. I taunt them with faces and foul imagery. I play my guitar loudly in corners to send them shockwaves of noise and hatred. I use every moment to fight against the spies. I await their eventual collapse into the physical world, I will win this, but this spectacular victory never comes as the intensities build higher and higher in my mind. I keep the blinds closed but put away the weapons before Genevieve returns home. I take baths to ease the psychosis, I drink sedative teas. Each bath I draw, there is no empty silence. I hear birds chirp. That is Them. I hear children’s voices. That is Them. I hear cars accelerate at the intersection. That is Them. Every noise affects me, digging into my guts and piercing what is left of my life. There are razors on the side of the bathtub. I look at them and they move. The voices tell me to kill myself, and I fight for my life. I grip my guitar with terrible force and play as hard as I can play to drown out the chaos. I resist the sounds of the hounds with a high-pitched fever, strumming until it sings like a piano. I beat and beat my instrument until it smacks like a drum, begging for silence, some kind of end to all this:

Figure 3: “Peaceful Silence”, Recorded September 27, 2013 (Available: <https://www.youtube.com/watch?v=TGIgc2sV6qY>)

Every day goes something like this, and I am afraid to leave the apartment. When I do, it all becomes a game. Snipers aim right straight at my heart and I taunt them with my walking stick. Go ahead, shoot! Do it! Shoot! I tell them in my mind. And they never shoot. I want to live, but I want to die. End this suffering with one shot, but I think about my wife and I must live on for her. She is one of the few real people left I believe is on my side. I will get through this for her. Even if she is no longer here, even if her body has been replaced, somewhere out there I know she's still real. I will keep myself alive for her. I will not let them win for her. I put on the best act I can for the world around me, watching as I suffer. I am becoming utterly alone in a sea of people and mountaintops for clouds.

I walk along the entrails of the promised land and all I smell is sewage.  
I hear the faint echo of the unimaginable,  
The tumor of war, all coming from the inside.

The flesh cut limb by limb in the pot. The snakes, the acid, the inescapable. The entire human race thrown into hell on my cold, miscalculating behalf.

And only I can't see,  
Except in my dreams.  
Death is everywhere, the threat of perishing,

This is life, I thought.

A sniper's aim, a grim smirk,

And every retort sounds the same.

Who is anyone? Even myself. You all should die for what you never did. For what I don't do is what you believe, I believe.

The carpet is mustard yellow, your loved ones are in your mind, and then they hate you,

Because you hate yourself and what you never did.

The guilt of thought is like a poison, but not in so many ways. Because you still live, wondering why you didn't die, and now it is forgotten by the people who never knew.

But the pot still grinds, and you continue,  
Knowing only the capacity for yourself  
Has been tested.

*~Poem written November 12, 2015*

I call for justice against the voices torturing me. Visions of horror overcome me. Pots full of blades and fire, snakes and poison, grindings of flesh and sinew, this is where I will go. Dreams of the unimaginable. Not me, throw them into the pot! Torturing bastards taunt me with the place I am condemned to venture. I see ghosts trapped in fire and a merciless figure pissing acid on their skulls. My body quivers at every thought, and I open my eyes screaming inside from these dreams. But there is no more dreaming, you awake to your sleep. There is no pause of reality. I can't shake this, I can't shake this, I can't shake this. Every sound is the pot, every smell of burning. I must plot my revenge soon, and take them out before they take me. But do I even care enough? Do I have enough in me? Oh will my body ever fail in this state? What can a man take?

I cry out for justice at the spectators watching this. Where is my lawyer, where is a judge? Who can remove these spies seeking my life? Do I not have rights? Whoever is reading these thoughts, please listen, I am afraid and alone. Will you help me? I write on my iPhone:

It is 9:30 am on November 5, 2013. I have stated aloud in my apartment asking if there is a judge, a member of the Canadian judiciary who is listening to this conversation. I have asked if a judge can inform me of my rights at this moment since I have reason to suspect that there is intensive surveillance, or other forms of surveillance on me.

But nothing ever happens. One day I take matters into my own hands. I run outside and begin swearing at every person I see. It is early morning. A police officer pulls up beside me. And

he asks me politely to stop and talk with him. A voice tells me to run so I sprint home. He drives his car beside me and asks me to stop and I keep running. He jumps out of his car and tells me to get on the ground right away and I keep running. I run all the way home back to my apartment and lock the door. I draw a bath and calm down in whatever way I know how. They knock on my door and ask to speak with me but I do not answer. It is not really the police, I think, it is the agents against me. I stay in the tub. They knock again, and then leave. I find out later they talked to the apartment superintendent, who gave them my wife's cell phone number. They pick her up from work, and determine from her timeline that I could not be the person they suspect of having committed other dubious behaviour. They ask her why I would run away from them, if I did nothing, and she tells them I have been suffering from mental health issues, that I am critical of the criminal justice system, and that I am afraid. The Sergeant, surprisingly, is compassionate and understanding, so they leave, and I live on to chase down my life another day. I live on, with a mind like this:

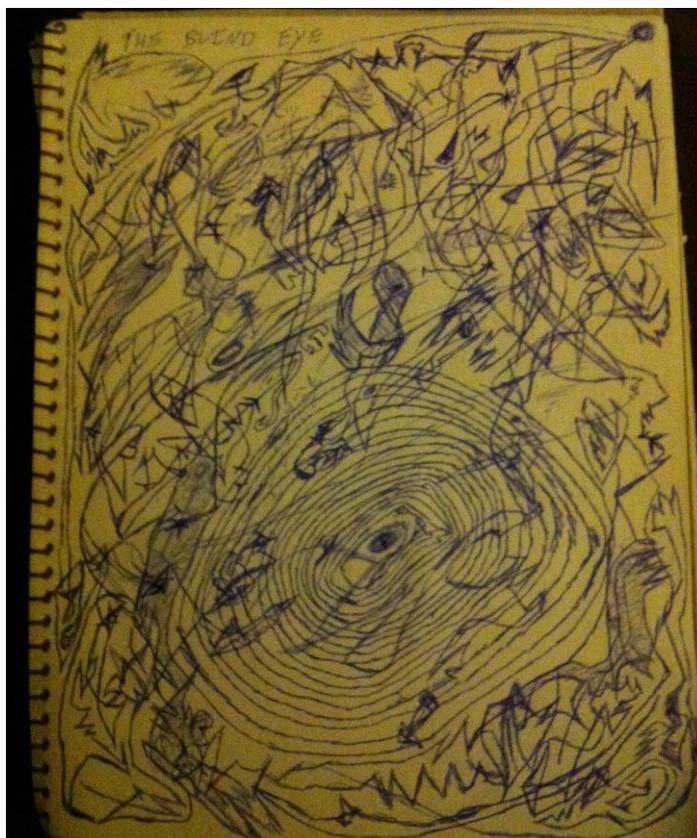


Figure 4: Sketch of “The Blind Eye”, drawn during my psychotic episode.

Weeks later, I search my body and apartment again for cameras. I find nothing. I take my keys from my wallet and lick them. I start to become ill, and a voice tells me to immediately call 9-11. I nearly faint on the floor and awaken when paramedics and police enter my apartment. I ask the paramedic several times if he is truly a paramedic and he laughs at me and says yes. The police try to convince me to come to the hospital and I refuse to do this. So they arrest me. Both are large men, one hailing in at about 6’8 and the other about 6’3, all well over 200 pounds. I grip my couch tightly and panic. I say no, no, no, and they lift my scraggly, 160 pound body from the couch and turn me around. The larger cop lynchets my left shoulder, the one that was surgically repaired and I yelp and writhe in high-pitched pain. I do not fight them back, how can I? I tell him not to pull it, I just had surgery on it, and he tells me, “just don’t fight it”. This all happens in a blink of an eye.

I am pissed off and terrified. This is it. They place me in handcuffs while the other male jokes if they should double-cuff me. I beg the larger man not to take me alone in the elevator with him but down the stairs, but we go in the elevator. But he doesn't kill me, he just waits patiently for it to come to the lobby floor. They place me in the back of the police van and take me to the hospital. A man in a Canada Post van laughs and signals at me. When I exit from the back, he tells me I am under arrest in accordance with the BC Mental Health Act. I wait in the lobby room and plead to see my wife. They keep me in cuffs. I call my mother and plead with her to fly out West and take me away from this place. She tells me she cannot do it, and I think it is because it is not really her on the phone. I go to the Psychiatric Emergency Unit.

There are bodies lying around everywhere and the first thing I am told to do is piss in a cup. I wait on a chair, while a middle-aged woman, a patient in a gown, makes cry-baby faces besides me. She taunts me. I am crying, and see this all in my peripheral vision, but I refuse to make eye contact with her. I have more to worry about. I want to leave this prison soon. I can't survive here long. There are no beds and half the population looks dangerous. What do they have in store for me here? Finally, Genevieve enters the room and she hugs me. A good sign. I tell her I am feeling better and she doesn't ask too many questions. I talk to a doctor who tells me he is interested in knowing who dealt me the cannabis that I smoke. He tells me he is trying to get information for the police. I do not tell him anything. Pissed off, he leaves the room, and a nurse takes my blood pressure.

A psychiatrist introduces himself to me. I ask him if he is a real doctor and he says yes. We explain to him how stressed out I have been with school and that I have been having a bad reaction. He asks me some questions. I answer them politely. He asks me if he can let

us out of here now, and we say yes. And off I go. The voices haunt me again that night. My life is on repeat:

Into the chaos, the empty cans run against my cylinders

Like the sea,  
I breathe in, fight the air, take one last dive,

And so I swim a little dim,

Which car do I take?  
No wings on me, the airplane bleeds

Or do I? Where are my eyes? What's left of the song? So many wrongs.

To writhe and agonize, to scatter yourself everywhere. There's nowhere to go. Beg, be consumed. Slow down, consume me.

Or to slowly await a pause in time. Realize that final shiver. I can't...feel. Now make it quick.

Wake up.

Go to the door, nothing is there. Wait. Go to the door, nothing is there. I said wait, wake, wake up.

(You're never dreaming)

Now the window, the birds speak. Crows? Throw a knuckleball. Gibberish. 3. 2. The seagull flies over the tree of life. Just like the last thousand times. I wasn't counting. The man with his hands in pockets. He has a gun. 2, 3. The numbers of torture.

The birds chirp by the window. The children are brainwashed. Corruption, giants, men in buildings.

Resist. Make noise, turn into a monster. Get them all back. It will all be over soon. Keep telling yourself that. It's not over. Go for a walk. Taunt the snipers.

Then listen to what the songs say. The dead still speak.

Take a bath. The razor falls into the tub. You wish. I'd rather go down blazing. Pot, smoke pot. Suffer, be silent, hear, hear what you hear. See what you see, see. Think, thought, "Throw them all into the Pot".

Snakes and machines, grinding, blades, fire, acid, they'll never die. Who are you talking to, Commander? And why?  
Dream it's your turn. The world smirks. Everyone, sooner or later, smirks. Exactly when you want Them to.

I'd rather be frozen.

Until you're cold. And it's all for nothing.

*~Poem written November 21, 2015*

### *Matthew vs. The Psychiatrist*

As the days pass on, I am taken to another doctor at a walk-in clinic. He clearly identifies that I am stressed and refers me to the University campus to see another doctor there. I am taken to the University doctor and she wonders about my thyroid. She has me fill out a psychological questionnaire, weighs me, and then I leave. At this point, everyone around me is a robot. Everyone around me wants to kill me, a circus from the inside-out. I have no thoughts, but a small will to live on. To play games with my enemies, to fight them off with made-up tactics. I eventually see the psychiatrist on campus. All my hatred against the mental health system has boiled to this point, a toxic stew of the hundred indignities I witnessed during the course of my work as a security guard...[or something to this effect]. All my distrust goes into that room, and I am ready for the fight of my life. The voices in my head tell me to have fun.

I sit in her office and begin drawing immediately. I take notes. She asks me later what I am drawing and I do not show her. I ask her if she has any of my history and she tells me no. She asks me questions about my state of mind and my family and I barely answer them. I interrupt her, I take bathroom breaks every 3-5 minutes, and she patiently allows this. I make faces in the mirror. I re-enter the room abruptly, and one of these times I watch her read something on the computer screen. I ask her what this is, and she says it was a report from

when I went to hospital. I confront her, saying, I thought she didn't have this information, and she tells me that now she does. I continue drawing and sketching, writing dark images all over the pages in front of me. This wasn't fair to her, I think now. What did she do? But I am angry that she did very little to help. I confess to her my insecurities about the mental health system. I bring up Thomas Szasz's work. I ask her, what in the DSM, would she categorize me as based on her assessment, and she responds immediately, Bipolar I Disorder. I tell her I cannot accept that. She asks me if I would take some medication to help, and I refuse. And then I leave the room. I tell Genevieve nothing, but later on the phone, I admit to my mother that the psych said I was Bipolar. Genevieve is angry I did not tell her, I learn later, when she was no longer a robot. She convinces me to go back and grab the prescription the doctor left me. I agree to begin taking 1mg of risperdone, even though I believe it will poison me.

When we get back home with the drugs, Genevieve hands me a pill to take. I look her in the eyes, understanding that this is it. The onslaught of voices tell me to take it, taunting my immanent death. I don't respond in my mind to Them this time. I have accepted my fate. This has gone on too long and there is no way back. It's over. I take the pill, lie down on the bed and close my eyes, and I feel an effect. Suddenly, the darkness in my vision turns to light, and I am guided by a tunnel. I believe I am dying. I stop breathing, I cannot move. All voices turn off but one. I see a man, whose face is pure light, and he says to me, "Matthew, what has the world come to?" He extends his arm and asks me, "will you take my hand"? I answer him, yes.

Figure 5: "Paranoia", Recorded November 13, 2017 (Available: <https://www.youtube.com/watch?v=TGlGc2sV6qY>)

*Fight and Flight Back Home*

The light turns back to darkness and awaiting me are dozens of figures in my head, angrier, infuriated, and more certain than ever of my immanent demise. The next morning, after Genevieve leaves for work, a voice tells me to pack a bag and get on a plane and fly home to Prince Edward Island. This is my only chance. I pack my bag lightly and I leave the apartment. I fear the taxi driver on the way there, I fear the airline attendants trying to get me to layover in Calgary. I refuse every suggestion, and I get a ticket with layovers to two Canadian cities. I navigate the circus of the airline. I get through security clearance. Genevieve finds out my plans since I called my parents ahead of time and asked if I could come home. An airline attendant approaches me as I wait for the plane, and informs me that someone is very worried about me flying home. He tells me I am an adult and still have the right to fly, and I exercise this right, since I know the people trying to keep me behind are after my life. He leaves, and I board the plane.

Many people sitting beside me on the flight want to kill me. At the first layover, I am told by voices not to budge an inch, lest the young man in front of me takes me out. I am told I am being protected by counter-forces who are relying upon my movements to rescue me. I make it to the second layover and decide I cannot fly any longer. I take a cab to the bus station and purchase a ticket to PEI. I wander around the streets looking for a hotel. I call my mother for help who talks to me as I search for a place to stay. The first three hotels have full bookings but then I find a room after midnight. My mother convinces me to just use my plane ticket and fly to PEI, as a storm is likely in the Maritimes. The next morning I refund my bus ticket and go back to the airport. I eat and drink very little, and I feel my body beginning to shut down and grow weary. On the plane to PEI the man besides me makes a

noose around my head on and off during the whole flight, foreshadowing my execution. I ignore him the best I can, and scoff at the smell of his armpits.

When I greet my father at the airport, he barely recognizes me. I soon realize he too is a robot. I meet the dogs at home and my mother and brother. They are robots also. Where is my family? Am I really in Ottawa, not PEI? The street names trigger me and I have no sense of place. I am taken to see a physician who prescribes me a sedative and more risperidol (1mg). I grow more paranoid and confused at my parent's home. I refuse to talk to Genevieve any longer, because I do not believe it is really her. She becomes distressed. My mother pulls some strings and gets me another psychiatric appointment. Following our meeting, my doctor writes:

Matt Johnston is a twenty-five year old married man, who was studying in [the West Coast of Canada] to gain a Ph.D. in Sociology. He and his wife, who works at a veterinary clinic, were married in August.

Matt was referred to see me by [doctor], who saw him at a walk-in clinic. Matt's mother, who works as a nursing supervisor, contacted the [mental health clinic], hoping that he would be seen quickly. [Nurse], intake worker at [mental health clinic], had spoken with Matt and his mother briefly and asked me to see him on an urgent basis, which I was able to do by moving some patients today.

Matt reportedly was doing fairly well up until September of this year. He was at home, recovering from shoulder surgery and began speaking about wanting to move out of [Western city]. Over the next month or two he became convinced that there were cameras placed around their apartment and he started ripping apart the walls to find them. His wife called an ambulance, who called the police, who took him to hospital.

I understand from Matt's mother, that in hospital, he was diagnosed as having a stress reaction and not admitted, but given a prescription for 1mg of risperidone nightly, which he only took briefly. He did see a psychiatrist again after this on one occasion, but then abruptly made the decision to leave his wife and fly to PEI, which he did approximately nine days ago. He reportedly was quite disorganized at times and called his mother once, as he was lost in [Western city]. He explained that he did not want to get on the bus with "those people" and subsequently became lost. He would not call his wife for directions, as he did not trust her. Similarly when he made the

decision to fly to PEI, in [Canadian city], he planned to travel by bus, though he had a plane ticket for a “backup plan”.

Since Matt has been home, his mother reports that he has been very suspicious and guarded and at times, irritable, though he generally has a good relationship with her.

Aside from the shoulder surgery this fall, Matt’s mother reports that he has had no medical problems. His medications presently are quetiapine 25mg am and hs and risperidone 1mg q supper. His mother states that he reportedly smokes some marijuana but knows of no other drug use.

On mental status exam, Matt appeared his stated age, somewhat disheveled and gaunt and wearing a knit toque through the interview. He was initially guarded and reluctant to speak, particularly about his wife. There were some electricians doing some work in the building and we heard the sound of wires running through the walls. He suddenly became very paranoid and refused to talk to me anymore and rapidly left the room and the building. Before he left, he did state that he believed that his professors and his wife were doing things against him and that it was not a safe to remain in [Western city], though he would not elaborate on this. I was unable to elicit any hallucinations. Matt’s affect was restricted and anxious. His cognition was not formally tested and his insight and judgement were poor.

Diagnosis: Undifferentiated psychosis, likely schizophreniform psychosis.

Plan: I will admit Matt directly to [Psychiatric Ward] after discussing with [doctor], who is on call. He will need to be medically cleared and reasonably settled first. I discussed with his mother my intention to treat him with risperidone 4mg at hs and olanzapine 10mg bid as a prn, which she readily agreed with. I will add quetiapine at bedtime for sedation, as needed. I will not order more blood work at the present time as he has had blood work done last week, which showed an elevated bilirubin.

Yours sincerely,

[Doctor]

### *I Have Come to the White Walls*

I storm out of the doctor’s office. I’m leaving this place. I rush back to my parent’s car, and my dad follows me. My mother bargains with the doctor about what hospital I will be taken to. A cop shows up. Oh great, this again. He tells me I’m coming with him, and I tell him that’s not happening. He says I don’t have a choice, he’s just the taxi. There is a long silence while the cop waits by the passenger door. I try to close it and he throws it back open.

My dad tells me softly to try and stay on the voluntary end of things. There is another pause and begrudgingly, I go with the police officer. He opens the back door of the cruiser and I hop in. He plays the radio on the way to the hospital and there are more messages, more death threats. Surely, these are the last days.

The cop escorts me to the emergency department, where I wait in a hospital room. It is sterile, and less triggering. The table is small and uncomfortable, but I am used to sleeping still from my airplane travels. A physician enters with wide eyes, eyeing me up closely. He shows me my psychiatrist's notes about our meeting and tells me I am going to have to stay. He examines me. He presses hard on my stomach as I lie down. A security guard waits outside my room. I know his job all too well. I have to defecate, so he shows me the bathroom. After a minute he bangs on the door. I tell him I am going to the bathroom, irritated. He tells me it's time to get out. I wait longer in the hospital room. A nice woman eventually enters with a wheelchair. She wheels me over to the psych unit. She tries to talk to me on the way there. The door closes behind me and there is no exit. I have come to the white walls, indefinitely.

Figure 6: "Prison Hospital", Recorded June 14, 2013 (<https://soundcloud.com/user-234321408/prison-hospital>)

The place looks nothing like the hospital where I worked as a security guard. There is a living room with a television, a table for activities, and some open space rather than hallways to wander around. People seem to be coping here somewhat. But knowing there is no way out makes it clear it is no holiday camp.

I try to access my super powers to leave this place. I bargain with the voices to pull some strings and let me out. Why am I here? I don't understand the point of all this. I liked home better. I am shown my room, where a middle-aged man who coughs a lot in the night

sleeps beside me. I already feel the boredom. I have worn the same clothes for a few days now and I am sweating. What horrible experiments await me here? I am becoming a Messiah. I am trapped in a delusional world, yet also I am trapped here. I wait it out. The next day a doctor greets me and asks for information. I tell her very little. She is a robot. She wears keys around her neck and surely this is a sign. She holds the keys to my freedom and somehow in my delusions I know I must play nice with her. I change my demeanour and try to tell her everything. I admit I hear voices. It is clear I am paranoid. She tells me the medications I will take. I forget what they are. Every night at bedtime I take the pills. I get up for breakfast. I get up for lunch. I do jumping jacks and push-ups in my room to pass the time. I routinize myself. I bathe two times a day at precisely the same time. Play solitaire. Speak very little with the patients, who annoy me. Oh, what a jerk that Bipolar woman is. Always asking me questions and walking into my room. Just leave me alone, go tell your dirty jokes elsewhere. You disgust me. I do word puzzles even though they scare the living daylights out of me. I take control over the entire economies of countries through the crosswords. I command a large army in my head to keep fighting to get me out of here. I start believing there is a way out.

At some point during my first week I am taken for a CAT scan. The doctors wonder if I might have a tumor, because apparently I am not responding quickly enough to the medication. The doctor tells me it came back clear. I have no idea what she means, but I nod my head. She asks questions, I answer her questions. I'm always feeling better I tell her, but in reality, the world in which I live is still ingrained in my being. I have night terrors every night. I awake one night to an orderly flashing two fingers at me. Is this real? Have I really lost it? Is what I see not even real? I can't make sense of it to this day.

I call home occasionally and my parents' voices frighten me. I tell them I am doing better and my mother asks me if I will be let out for Christmas. I say I don't know. The doctor agrees to give me a pass. Hallelujah. I still haven't called Genevieve. I missed her birthday, and I am angry with her. Not her, but who or what I think she has been replaced with. It is terribly hard on her. She moved back home with her mom, waiting and praying for my recovery. Our dreams of the west coast and sunshine and mountains have been utterly crushed into oblivion. I have ruined her life.

As we open gifts at Christmas all I can wonder is how crazy my family thinks I am. Their passing glances, their pretending to make this all better for me. I am nuts and there is no hiding this. I am ashamed. I have been reduced to nothing. I have nothing. I have no freedom. I have lost my family. I have no job. I have no sense. I am not here. I have become a child all over again. I have a long road ahead of me and it is far from over. I play video games like I am doing drugs. I eat and sleep and make use of every minute I have of freedom. But then it's a day later, time to go back to the white walls. And there I enter again, and there I kill time.

A woman asks me most mornings if I want to go to peer group. I say, perhaps, but never show up. I try to chat with some of the younger patients at mealtimes. I play Trivial Pursuit, the expert edition, with some trivia savant, and I even beat him once. I refuse to play him again, after, because that was my victory and I was going to savour it. The nurses observe me, maybe it's a good sign I am becoming friendlier. I open up with one woman about some of my struggles but never let on what is going on in my head. During one activity a woman states that 'none of them are as crazy as Matt is', and I know then and there that my wounds are in the open. At mealtime I start eating meat again. I know I have to gain weight.

It destroys my stomach and I get terrible constipation. I drink the prune juice on the floor but nothing works. I ask for something to relieve it and I am told they will order something, but this never happens. I start to fart around the hospital, and this amuses me. I know the doors are air tight and there is nothing anybody can say or do – it is, after all, a medical problem. One woman says, “That can’t be good for the garbage” and I blurt out laughing. She tells her friend, “I told you he would laugh”. I have become a spectacle. I am dirty and I smell awful. I am crazy and I am to be feared.

After a couple of weeks of being ‘inside’, I am given 30 minute passes three times a week to go outside. I work this into my routine. I check my email at the public computers and tell some guy asking me to ship his books back to him to get lost, essentially. I apologize later in March, and get Genevieve to send them. I check baseball pages and the news. I think the news has everything to do with me, but it turns out that it doesn’t. I get some fresh air, and I see some security guards pass by. I look at the horizon and I try to see my home from a distance. I wonder how close it is. Snowflakes fall and I have no coat to keep me warm, but I do not go back inside until it is time. I will not run off, because what good would that do? I want to go home. I want things to go back to the way they were. I want to be myself again. And I return to the ward.

I am starting to feel better. My mind is becoming blander. Maybe it’s the drugs. Maybe it’s the institution. But I still feel like shit. The drugs are slowing me down. Maybe that’s a good thing, though, I think. I still dread being contained in a corridor with magnetic locks. But I am better, even if it means my liberty has been indefinitely taken. I find the staff treats us like children, generally. People are scolded for breaking rules similar to the ones imposed on you as a child. Maybe it helps them feel in control if we agree to be treated like

children. Maybe it's a good thing to feel that way, if it helps us recover; to feel like someone else is in control of our health.

The glorious day comes when it is time for me to go back home. I have lived in the asylum for a few weeks. My outtake nurses gives me a third lecture about smoking pot. She calls it poison, and I agree to never do it again. I want to also tell her to stop treating me like a child, but silence grips me. I am close to leaving. My parents come to pick me up. My dad has brought my phone. I play on it in the waiting room while I wait for the paper work to be completed and my medication to be drawn up. I go to urinate and an orderly opens the door while I am still going and tells me to give him my phone, since they are not allowed on the ward. I frown, scramble to zip myself back up, still dripping urine, turn and hand him my phone. He is a bit of an ogre, while most of the other staff are pleasant and less authoritative. But I will trade this indignity for the freedom that awaits me. When I get out of the bathroom a nurse lectures me again about having a phone. This is odd to me, but I suppose I am still technically a prisoner. After my family exchanges some words with the doctor, I am let free, into their care. I continue my recovery.

### *The Long Road of Recovery*

A lot of people reading this might speculate why it took so long for there to be an adequate intervention in my healing. But is madness always visible? Consider a picture taken of Genevieve and I in the throws of my psychosis in December of 2013, after she took us to a resort in hopes that some relaxation would ease some of my suffering.



Figure 7: A picture taken of us in December, 2013

I look deep into my eyes and see a lost man staring off into a distant realm. A fake smile, some glimpse that I know what I am supposed to do for a picture. And I remember, while the camera was flashing, the voices I heard. I remember my attention focused on them. I remember the sounds of the pot slicing. The horrors ripping apart my guts. I see the coat and sweater hiding my fading body. I remember walking around the fields, unaware at times that Genevieve is even around. I remember wanting to die. But what do you see? A happy couple? A romantic getaway? What did the doctors see? A stressed out patient? An angry, jaded man? A person in distress who did not require hospitalization? No one is aware of half the things I write on this page, unless I tell it to you. This is the invisible nature of madness and the mad person, they hide the truth. It is so horrific that one can hardly tell it all. Words just do not have that power. Madness is untold, it is a secret we have to live with. It is one that shames us. It is one that is unbearable. It is one that you just want to disappear, forever, into the abyss that birthed and nurtured it.

Underneath all of this also rests an agency. For starters, I am in control of this narrative. And even in the throws of madness, I engaged the horrors, voices, and delusions as

though they were real enough to tell me something about the world around me, and how to survive the people and nature that inhabits it. The people I engaged may not have shared my reality, but still I engaged with them relationally in a way that was pragmatic, considering how it pushed me forward both into terror and recovery. I may have lost control over the self in a spectrum of hallucination and danger, but I worked hard in my madness to regain some sense of agency, and then I mobilized it to help myself survive and interact with people around me that sometimes convinced others I was not totally mad, even though I was.

And the side effects of madness do not simply disappear after being brought back, somewhat, from its nightmare. The risperidone hit me, hard, over the following year. While it allayed my paranoia, I gained about 60 pounds in a couple of months, lost the ability to have or express any emotions, and appeared to be someone else. It was better than the crazy Matthew, but I was not the man Genevieve married, and she was patient with this. My entire sense of being was struck, I was transferred from the inferno to an ice-cold lake, and my thoughts were frozen in its deep stillness. The auditory hallucinations did not go away for quite a few months following my exit from the hospital. I kept silent about this, because I could manage them, they were more friendly now. I knew that if I told anyone, I would be taken back to the hospital.

And to hell with that.

My psychiatrist was convinced at the end of January I had been brought back to a normal state, and he didn't need to see me again for a few months. He even lowered my medication, which was somewhat of a relief.

Several months later I moved with Genevieve to Halifax where she began her Masters degree. Now it was her turn to try graduate school. I worked part time as a patient attendant

after getting turned down for other menial jobs. At various hospitals in the city I conversed with and gave love to the dying, and cheers to the sickly. I found this rewarding, but I also knew this wasn't what I wanted to be doing for the rest of my life. It was hard. I was an up-and-coming Ph.D. student with a huge scholarship, reduced to a recovering madman hanging on to a thread of life, with a hope that I could do it all over again, someday. I applied to Carleton's sociology program in the fall of 2014, and started publishing several articles based on my MA research to pass the days. I could barely feel anything, except when I wrote. For my birthday in February, Genevieve made me a diary to start getting my feelings out. This is the first entry I wrote on February 21, 2015:

The last year has probably been the hardest year of my life. I still feel like I am trying to regain everything I lost. I worry more than I show it. Throughout my life I always felt like I grew and moved forward. Now I feel stagnant, like a flower without any roots. Lost. There is a lot to live for, I'm just tired of waiting. Tired of my situation. I let my faith slip the last few months. I worry about Genevieve's sadness...she was content in the west coast – the adventure of it all was like we were in a new world. I never knew how lost I would feel being so far away from my friends and family. I wanted the adventure too, I had a lot of hate left in Ottawa from past broken relationships and friendships, hate that's long gone because I had new problems to deal with.

I'd hate any job where I don't feel like my true potential is doing good. I've just been so exploited over the years it's hard for me to move beyond my trauma. I can't stand how my parents pressure work on me. I love them and they have always been there for me especially when it's hard, but on some level I don't think they understand me.

Nowadays I hide a lot. I hide from confronting the deep insecurity I hold about myself. I worked so hard at school and got through so many challenges and now what was it all for? Tim Horton's wouldn't even take me. I got sick at the worst possible time. Some days I feel like I don't want to feel or express myself to prevent myself from having a depression that could make me sick again. I have been getting better, but my dreams scare me sometimes, my mind is too out there and I still feel like I'm healing...

Where is my passion, my drive, my ambition? Why do I feel like I lost my spark for life?

I can never stop judging myself. When I do this I feel like others around me are judging me. And then I get angry at them when it's really just my own anger at myself. When you hear voices you wind up confronting your conscience and the part of your mind that argues with you and makes you feel bad for being who you are. What was hard about [the west coast] was all the time I spent alone at the house...I think the solitude drove me crazy.

...Everyone knew how sick I was but in actual fact I was living in hell...afraid of everyone and everything. To believe every person, family member, animal, artist, politician is part of some conspiracy to kill you or save you from being killed...to have violent thoughts towards people because you think they are going to torture you. And to feel this for so long that reality no longer exists. All that is left is a memory of you. In some ways, you are dead. Because you've forgotten who you are. God allowed me to live though. I never stopped wanting to stay alive even though I felt surrounded by a dark evil cloud.

I want things to be alright. To feel like I am fulfilling my purpose...to be enveloped by a light cloud of bliss where you feel the full weight of your troubles fully comprehended, and dropped out of the sky. No pain, just truth.

My doctor's instructions in January, 2014 were to take the medication for a year. He believed I had a brief psychotic disorder, and that eventually I would return to normal. There were no guarantees though, and if I did not return to normal, then I probably had a form of schizophrenia. This terrified me over that year, because the medication was so horrible that I couldn't imagine living this way forever. I can't live psychotic but I can't live without feeling who I am. What a bargain. The months passed on, nearer to the date when I could wean off the drug, and my anxiety was high. I just wanted so bad to get back to normal.

When I got off the risperidone, it was like the best drug trip I ever had. I laughed for three straight weeks at just about everything. I had enthusiasm to work, enthusiasm to go out for walks, to tell jokes, to enjoy life. It was pure bliss, and the hallucinations barely came back. I felt somehow vulnerable, and I recall feeling mildly paranoid on buses and groups of people, but these feelings would generally go away. My brain was healing.

We moved back to Ottawa in late August, 2015, where I started the Ph.D. program at Carleton. I felt so energetic about the prospects of a new life, but also deeply afraid to fail, again. I wanted to do a Ph.D. right, but I wondered if I had the coping mechanisms to manage the stress. Genevieve was also pregnant, which was a joy and also something to be nervous about. I told people I met here very little about my experience, I found it hard, still, to trust anyone. I suffered from flashbacks and nightmares about being psychotic from time to time. I was especially afraid of people in positions of authority. And since I left the west coast so abruptly, I wondered if word had gotten around about my story, if people knew of my tale, if I was still a living spectacle. If I would ever shake the perceptions I imposed on myself. I still wonder to this day if I would ever be the same again.

Figure 8: “Will I Ever Be the Same Again?” Recorded November 15, 2017 (Available: <https://www.youtube.com/watch?v=TGlGc2sV6qY>)

### *Madness and Faith*

Most of what I felt, saw, and heard wasn't real to this world. I have to deal with that. But one event I hold back from this is the experience of the divine, the outstretched hand of pure peace, unconditional love, and healing, that moment in psychosis where I felt loved and free, and how that pushed me to live when I accepted death. From madness, a faith in me grew that has strengthened itself and been tested ever since, and it is that faith that allows me to live in joy today, even when the hauntings seek to overwhelm me. In September, 2015, tears poured over my laptop screen as I wrote this poem reflecting on what I salvaged from this experience.

I am haunted. Nightmares of the past, delusions, voices, fears, intensity, confusion, the surreal. I died, I came back. I have fought and won, but lost everything, even without anything to lose. I have been afraid of everyone. I have lived in other realms, unknowns, mysteries, faceless times; I have confronted hell, and forgotten my escape, until I am somewhere else.

War was inevitable, if you're me. There are mental collapses. There is madness. Pain. But there is no vision of future that will prepare you when you leave the dust you crawl on, and venture to the centre of the earth. Where you trust no one, where insanity creates the vision of Jesus for you.

No sleep, you fear sleep as much as waking life. Tortured in and out of consciousness. Shot in the dark. Crippled, entangled. Over and over. Unrelenting potential to die. Revenge befriends you. Thoughts of what you will do to yourself, who isn't really you, for what it does to you, but you never know. Your guts are gone. You still wonder, try to make certain. Everyone is a threat. And then a robot. And then a robot who is a threat. The anger you held back at everyone is released.

And when it's all over you have no emotion. You are plain. You don't remember before, during, you are now after. There is no illusion because there is no creativity. You walk straight, and that's it. The dreams slow, the voices slow, the doors to the unknown creak in your sleep...but nothing appears, without prediction. And slowly, you die again, in a different way. And I begin to wonder if this is somehow worse. To be nothing or to be something else, who was I?

I ask, who was I? Am I him again? Where am I?

And so I hold on to the family that carried me through and the God I felt.

But I will never fully be out of the dark.

But so the light of the heavens awaits when I return, for real this time. And everything that was, is better, and everything that is, is again. And the lies of my head are washed away, and the comfort of healing knows no trauma, and I am forgiven by the people I took with me, who were behind me the whole way when I never looked behind. Because God knows I couldn't. And so they helped me.

And the dreams I control just are, and the ones I don't, aren't. For the only thing I can be sure of now is love. Even when anger conquered me. I will know love, I will. For love knows me.

### *Chapter Discussion*

Mental illness can strike anyone, and the degrees of severity in which it manifests are endless. It can take you and everyone around you down with it. It can also enlighten us, and show us a better path. Psychosis can be defined by “crucial changes in thoughts and perceptions as well as in a person’s emotional and social life” (Solli & Rolvsjord, 2015, p.

67). As my tale demonstrates, this is putting it lightly. Most research involving people with severe mental afflictions focuses on the development of theoretical and clinical frameworks (Freeman & Fowler, 2008; Wood et al., 2018) or alternative approaches to help people (Bentall, 2009; Fledderus et al., 2010), such as music therapy (Gold et al., 2009, 2013; Solli & Rolvsjord, 2015). The relative silencing of the voices of mad people allows the perspectives of others to dominate understandings of how madness is experienced corporeally (Strauss, 2008). While generalist knowledge about mental illness provides us with some of the story, it hides the fact that some mental health experiences can only be known, to a certain extent, by the person experiencing them (Slade, 2012; Geekie et al., 2012), and thus my tale contributes to broader literature on severe mental illness and recovery, hearing voices, and mental health narratives (Bentall et al., 2012; Davidson et al., 2005; Kleinman & Good, 1985; McKenzie-Mohr & Lafrance, 2017; Slade, 2009; Thornicroft & Tansella, 2005).

While it didn't kill me, mental illness reduced me, for some time, to nothing. I ran away from my wife. I stopped trusting my family, and my livelihood was crushed. I became broke with a great deal of student debt, and I questioned if my mind would become strong enough to continue my studies. I had to endure a great deal of trauma. I have seen and experienced things I would not wish upon my greatest enemy. I have been made into a ghost, my very self disappeared into a vacuum, and my spirit lifted away into an otherworldly realm, more evil than it is unreal. And I lived there for months, dragged by the throat, so far down and away from the life I had built for myself. Words collapsed into a chaos; I became a body without organs, speaking and hearing without coherent articulation while still functioning as an assemblage made up of deteriorating parts (Deleuze and Guattari, 2009).

We can label this process alienating and sickly, therefore critical psychiatric research cannot deny the existence of mental illness (Szasz, 1994), it can only deny the extent to which the mental health system can help those in despair.

My narrative demonstrates that the mental health system does make mistakes. It did not take me seriously at first, and what treatment it gave me was not always effective. I escaped adequate intervention multiple times, while my mother and my wife tried over and over to heal and rescue me from the pit of my mind. Even when I could literally no longer see them, my family was still there. As we learn in the next chapter, when family support is missing, one's chances of survival become worse. My family saw me through the torment in the 'here and now', and also oversaw my recovery and mental rehabilitation. They very much shape the production of this text (Boschma, 2007). I could stay angry at the indignities I experienced unnecessarily, such as police violence and mocking, and routine infantilization during my hospitalization (see Holmes & Murray, 2011, 2012). But it must also be said that the mental health system eventually saved my life, and this reality gives me a sense of hope that we can achieve a system that rescues more people and gives them a better quality of treatment and life.

Was madness just torment, or did it give me something? While the voices played with me, taunted me, turned me inside out and scarred my brain, some voices were not malevolent. Whoever told me to get on that plane made the right call, and whatever carried me home those days when I was in a completely desperate state, saved my life. I had agency in an uncontrollable state – something that most people pinned with a psychotic label are not usually afforded. The road to hell may have been dark, but it led to an experience with a deity (see Gale et al., 2014), and while I count most things as unreal during that time, that

experience has become the cornerstone of my Christian faith, which helped restore my life and identity, and helps give me the will to live and move forward. I hold onto the experience of the divine. Nobody can take that away from me. Madness gives pain, but deals knowledge of spiritual dimensions otherwise inaccessible in the realms of normality (Farber, 2013).

Alongside this faith, however, I still must grapple with the darker side of the spiritual realms I encountered. For some time, I discounted the devils I struggled with as fabrications of my mind; hallucinations that served no real purpose. But to disqualify those experiences as unreal and my experience with a deity as real masks an illogic and begs the question: how does madness reveal the Real in a world of utter fantasy and delusion? I argue that madness, therefore, as an ontology and radical departure point for praxis, is the uncalculated break from fixtures of Truth and Self to the occupation of the ethereal chasms between such territories. In varying intensities and degrees of liminality, this vacuum can push, pull, and jerk around its subjects as far as the supernatural outskirts of total darkness and bliss. Sadly, close enough contact with the shadowy and mysterious caverns that govern ineffability and crisis can leave service users paralyzed and unidentifiable, just as the life, meaning, and glory that accompany surreal existences are sure to leave others wanting more. Even if resolutions of the Spirit occur in these descents and ascensions, those of us returning, in some form, to the sober and realist terrains of consciousness cannot provide others (let alone ourselves) with a finite sense of comfort. For the future of madness can never be predicted or stabilized: that realm has always run parallel to the world, nor can we claim the worthiness of knowing truth the way madness does.

There is a relatively large body of work that engages first-person narrative as a strategy to preserve and explore self-identity when illness threatens to fragment it (Church,

1995; McDonnell, 2018; Michallat, 2017; Stone, 2006). Existing first person narratives of madness confront its triggers and symptoms in ways that look to rebuild, strengthen, and reinstate self-identity in the face of its disintegration (Bassman, 2007; Burstow & Weitz, 1988; Pembroke, 2009; Romme et al., 2009; Russo & Sweeney, 2016; Shannonhouse, 2003). This work places understandings of madness in the control of the authors, and often challenges the more pathologizing narratives of madness and its reactions in the mental health system, which sometimes work to condemn other-minded people (Capponi, 1992; Michener, 1998; Shimrat, 1997). These understandings can be in juxtaposition to the social realms and “interpersonal networks of others” (Michallat, 2017, p. 176) that entangled, threatened, or nurtured life and identity. By sharing the work it becomes a public exercise where narratives build an audience through vulnerable speech and “hostile energies” (Stone, 2006, p. 54). In another study, people who experienced psychosis found music to help them experience freedom, social contact, well-being, and symptom relief (Solli & Rolvsjord, 2015). It was an opportunity to connect with peers and transform some of their pain and ineffable experiences into art. Not only is creating empowering, but it can create a safer and more comforting space during recovery where people are desperate to make sense of their confusion and pain. While music did not replace formal mental health treatment, they reconnected with their inner-core and diminished personal identity, and the musical realm was conceptualized as an illness free space where their pain could be, if only temporarily, forgotten and displaced.

My guitar was certainly an escape during the throws of madness, and a way of putting to words the ineffable – the mysterious life forces to which language bows and holds silent (Brown & Tucker, 2010; Butler, 2001; Larabee et al., 2003). Though I drowned in internal

war, against the capacities of my mind, I fought them with the strings of time. I drummed away their intensities and sang out against their weapons. I experienced relief and victory in these moments, and displaced myself from the nightmares that would return to me in my lack of sleep. Art, as a medium to express madness, now tells the story of those traumatic excesses. The drawings, poems, diary entries, prose, and songs I have shared here thicken the plot, and shape the intensities that made me come undone. I am pieced together again in this story; the sounds and strings and poetic words hold me back up. I am coherent again, and even if madness returns, madness will not remain, but these words and sounds will remain.

Mental health recovery in a general sense is less about symptom remission or reduction, and more about being able to live a manageable life under stigmatizing conditions and other problems that illness creates (Tew et al., 2012; Topor et al., 2011). Further, “the process of recovery is linked to a higher degree with contextual and social aspects of a person’s life, where social relationships, social roles, and social inclusion are seen as crucial elements for a better life” (Solli & Rolvsjord, 2015, p. 69). Alongside varying degrees of assistance, most of us eventually have to steer the ship of our recovery with the hope that we will gain self-determination, community inclusion, and hope.

My recovery began in the throws of madness. I became agential, moving in footsteps, through the deluded world, searching for something or someone to take me away and heal me. I ruffled through the many voices in my mind and became allies with those I felt were on my side, working for my good. I called upon them when the demons were threatening my life, and they gave me coping mechanisms that I drew on to continue surviving. While I was lost, my family, in the more real world, were trying to get me help, taking me to doctors I could not see or understand clearly, who while confused themselves, often understood that I

was sick and needed some kind of treatment. But I also resisted their discourses. I had the agency to take back some control over my treatment and, because my sickness and past experiences with the mental health system were building and intensifying, refute the claims of psychiatrists, which did not end up always working to my advantage. One doctor saw through these hesitations and fears, and labeled them psychotic, which resulted in my eventual hospitalization, appropriate medication, and eventual return to a sounder state of mind.

Recovery, for me, is still not easy, especially since I still encounter trauma and hauntings from these events. The medications hit me hard and unravelled my sense of self, my affect, and my livelihood. Thinking psychotically can be dangerous, but removing the ability to think, laugh, rejoice, and express these hauntings is a different kind of nightmare. This was the option present to me when I faced this kind of distress, and very quickly, life stopped feeling livable. I was afraid to stay on medication, and afraid of what would happen when I got off of the pills. Now back on the meds I recycle the same fear, even though to date my experience has been better than before. This is the pain I must navigate. Oh well, life is tough, I tell myself, this is part of the healing process. But recovery, in this narrative, is not finite. There is no true coming back from the blackest of darkness. I can suppress it, but as one participant in Chapter 7 remarked to me during our interview, “it never really goes away”. But if these shadows follow me to death, it was never without a fight. Let the resiliency of this narrative empower others and join forces with other tales of psychiatric survival as we work to build a deeper and better knowledge of mental illness, resistance, and navigation in a messy yet positivist mental health system that is sometimes wilfully ignorant of the screaming humanity of those it claims to serve.

## **CHAPTERS 6: GOING PSYCHOTIC: INSTITUTIONALIZATION, RESISTANCE, AND SURVIVAL**

### *Introduction*

In this chapter, we encounter two narratives detailing experiences with psychosis. Doug's story begins with some recollection about the history of mental illness in his family, and the personal struggles he was dealing with before his first psychotic break and eventual diagnosis with Bipolar I Disorder. He then takes us through his journey with paranoia, hallucination, labeling, and hospitalization. Doug's family positioned him as a victim who no longer had much agency to achieve anything in life. Doug's story is full of passive resistance techniques he used to navigate the horrors and authorities present during his hospitalization, as well as his family's positioning of his identity. Doug resisted his parent's stereotyping by eventually obtaining a university degree, and he also resisted some of the hospital's policies and procedures through techniques of passivity and hunger strike. Still, he enjoyed aspects of hospitalization such as having very little responsibility and time to relax.

Jermaine, on the other hand, experienced similar psychotic symptoms but never had an adequate response from the mental health system. His story warns readers of the dangers of prejudice in an overburdened, ineffective, racialized, and error-prone mental health system, and how some people do fall through the cracks even when they present in an extreme state of distress. In his case, family was more or less absent in his recovery and struggle to survive abhorrent living conditions and homelessness. Jermaine's story is full of survival mechanisms rather than overt resistance to system officials. Unlike Doug, he was very compliant with medical staff throughout his narrative.

But survival and resistance are interrelated here, as both Doug and Jermaine had to struggle for their lives and sanity while navigating often brief, difficult, and authoritative

relationships with a myriad number of mental health professionals. In both cases, we learn about how mental health service users fight to remain agential during serious mental illness; negotiate complex medical relationships and (often brief) interactions; build positive reflections about mental health and mental health identities in spite of tragedy; and take control over their longer-term health and treatment goals. Jermaine though would have welcomed any intervention by system officials rather than be left to fend for himself during his illness. Doctors blamed his psychosis on his socio-economic status, and felt that obtaining more money would have resolved his problems better than anti-psychotic medication.

By the end of this chapter, readers will have a deeper appreciation for the ends that some people in our community go to in order to survive dire circumstances and breaks from reality. These narratives identify many limits of the Canadian mental health system; namely, terrible drug side effects, perceptions from family members that mental health service users are incapacitated, overt displays of power during hospitalization, sedation of serious mental illnesses rather than adequate treatment, violations of rights to self-determination for health, and general medical incompetence. On the other hand, we also recognize how people who experience mental illness navigate the good parts of the mental health system and illness. The benefits include valuing mental health labelling for the relief and explanation it offers service users, users taking control of their life path and finding spiritual and epistemic enlightenment, camaraderie with other service users and a development of empathy, as well as inspiring accounts of survival even when there was a lack of adequate intervention. Through autobiographical power (Myers & Ziv, 2016), we will discover ways to both critique the mental health system and improve upon it.

### *Doug's Story*

Doug, a friend of mine, lives alone and has been struggling financially for a few years. After agreeing to do the interview, we met for lunch and he took me to his apartment. He lives humbly, with a wonderful cat, and through social assistance and precarious contract work has managed to acquire what are basic necessities for his life, such as a computer, mattress, weight set, and several books. His apartment reminds me of my days living in Halifax during my recovery, when the apartment was less clean, and we were less sure of the character of our neighbours. He is somewhat unhappy, has learned to tolerate a lot of hardship, and makes do with what he has.

After his first psychotic break, Doug was diagnosed with Bipolar 1 Disorder, and takes Lithium for treatment. The drugs make his hands shake and this is always noticeable as we talk. These are the scars of treatment, and the visible wounds of his pain. He prefers Lithium over risperidone though, which gave him bad weight gain and bad feelings. At present, he is compliant with his medication, which was not always the case in his past and (in his purview) helped lead to more psychotic breaks, and bouts with Depression. Doug begins the interview by describing how his mental health journey began.

Doug: It was taking shape, like the troubles were starting to become apparent, I must have been...18, 19, 20...it all came forward with my first serious girlfriend. We had been together two and a half years and...that relationship was kind of like spiralling out of control into like a deep dark pit of very bad stuff...But around the same time, I guess my parents and I, we came to the idea or agreement that maybe the relationship with my parents wasn't working out very well. Like my mom [who is also Bipolar] was very difficult to live with...So I moved to [Canadian city] for like a year...And uh that one, like the first psychotic break happened...Then like 3 or 4 months after the first one, I had my second. And then in like six months I had my third.

Many people are fragile and vulnerable at a time of relationship struggle and loss, and that vulnerability began to cave in amidst other worries and strains. Since his mother was not a

secure and safe figure during his early adulthood, Doug moved away and tried his luck at post-secondary school, which also led to disaster. For most of his life, Doug had difficulty holding down a permanent job. The things that make life inherently livable for most people: work, school, love, and family, all fell apart, and not long after, he started to lose his mind as well.

In the face of this anguish, and searching for some kind of explanation as to why his life was spiralling downwards, Doug recalled how he felt when he acquired a psychiatric label after his first psychotic break.

Doug: So at that point I was diagnosed. A label was thrown on it [Bipolar]. And I remember being relieved that there was a name for it. And it wasn't just that I was a complete failure. Like that maybe something else was kind of like influencing all of this or...strong-arming me into failing so many postsecondary institutions. So it was nice to be able to put some sort of label or explanation on it...like things slowed down dramatically for me after that. And...I guess this was both necessary and good but, ultimately frustrating and instilled in me many bad habits. Um...because I was told that after a psychotic break it takes a year for your brain to recuperate.

Doug sees his label as a partial explanation for why his life fell apart. Pathology, to him, provided some reassurance that external forces beyond his control were shaping his nightmare, and that he should no longer fully shoulder the blame for his decisions and present situation. Alongside this reassurance, though, came the acceptance that his life would be harder than it is for many others. Doug took the diagnosis as a sign that he needed to slow down and consider what his limits were, which led to frustration and a detour from how he normally went about his life. This was hard on both him and his parents.

Doug: My parents took this to heart and they're like well you can't do anything then. You have to sit around and just take it easy. Don't stress yourself. Don't do anything like crazy. Don't take any big projects. Like...take one class...like I did refuse to like...drop everything, [but] I'd get too depressed and I'd drop it. My parents humoured me. Because I didn't want to stop, so they would let me register and take classes. Fun fact is that after I [graduated university], my father told me like after I got my diploma basically that he didn't think that I'd ever be able to do it...So

although I didn't feel like they showed it...I don't think they really held up much hope that I would be able to do all that much.

Doug's parents, while arguably looking out for his best interests and fearful that many activities could send him back over the edge, viewed him as incapacitated and restricted from everyday living. Doug fought this framing and responded to failure and despair by trying over and over again. In his family's eyes, his sickness defined him – the fact that he knew that they were humouring him tells us that he carried the stigma of mental illness on his back throughout his journey. He fought this stigma, but also had to accept that some of his family's perceptions were also true. His mental illness was holding him back academically and preventing him from accomplishing his full potential (Hitlin et al., 2015; Moses, 2014), yet his determination to keep pushing forward anyway was equally as strong.

As we moved away from discussions about his family, I asked Doug if he was willing to share what being psychotic was like, since we had talked about this before over beers in the year prior to the interview. Like myself, he experienced highs and lows, peaks and valleys, darkneses and lights that ordained his descent into madness – a story he can only partially remember.

Doug: I don't know if this is true or not, but it feels like I only remember like 20% of what happened. It only started to really come back as something I can count on in the past few years. It seems to me that everything that happened is like a dream...when I look back on it just feels like, I was someone else. Like it...it wasn't me...The first, the theme of that break was my friend who was the guy that I played a computer game with online. He was trying to kill me. And uh...he was a bit of a hacker too. He would break into my computers and like leave notes and talk with me like that. It was all in good fun as far as I know. But take that, that's like a pernicious type of idea and insert that into psychosis and like I was, I thought that I was being surveilled. And I thought that people...and it was plausible because I guess he did have the skillset. But what was impossible, he would like hack Bell [a Canadian phone company] in order to hack my phone. But that's a jump I was willing to make at the time. So...like my entire theme I guess for that was that I had to run away from that so he wouldn't kill me. So I just like got on a bus and I went downtown to [Canadian city]. And we're walking along, it's probably the canal. And I took all of my ID cards, my wallet, and I

threw it. It was winter. So I threw it in the middle of the canal, and it was like frozen...I must have been stressed.

Doug possesses exceptional computer skills. What started as minor hacking games amongst friends ballooned into events that triggered and heightened his paranoia. Psychosis was becoming interactive, playing on his skillsets and past experiences to create a visceral horror. And the more his reality caved in, the less Doug was able to separate delusion from actuality. Yet he treated the hallucinations as real in a way that showcased his agency to resist being totally captured by them (Davydov et al., 2010). These resistances may not have brought him back to realist dimensions like some medications might, but it demonstrates a willingness on Doug's behalf not to surrender completely to the horrors of mental illness. While he was losing control, he was also set on maintaining some element of control even as he fell deeper into the chasm.

Doug: But in a way it was, it was also controlled. Like I still felt that I was in control. I felt that, these bad things were happening but I still felt that I had some control over it. Still exercising my agency, because I was like doing these things. I remember I must have walked 30 kilometers that day. Like throughout [Canadian city]. Of course I was very being careful but I was like on a mission, I was doing it...I hope I'm not like mixing up two different breaks because they kind of feel interchangeable at times but that one I ended up at my friend's place and like he called the ambulance on me.

Before Doug experienced formal intervention, he depicts his psychosis as a mission. There was purpose beneath the layers of reality that toppled on one another, causing him to dispose of his identity cards and any financial tools to sustain himself. He was attempting to build a bridge from the psychotic state to the outside world (Bjornestad, 2018). Throughout my paranoid travels, I too was on a mission, seeking gratifications that never came, following what I thought would be immanent enlightenments, and pursuing a belief that what the voices told me to do would bring an end to my current life course and psychotic state. Doug's narration of psychosis is a blur that catches glimpses and moments of the nightmare here and

there, and finite pictures of reality. It is not until Doug meets another friend that he is taken from the city and placed in an institution.

Doug: At one point I was in a gurney. And they had strapped me down. Because I was trying to leave. And...I remember like my first stint in the psych ward, like so, they, I mean you don't get to have anything on you. You're like in a gown and that's it. Right? And your underwear, that's all you got with you. So like the guards and the doctor, they kind of escorted me into the psych ward, I like looked around and I watched them leave, and thirty seconds after that, I was out the same door. And ten seconds after that, they put me back in (laughs). But I wasn't all there...I remember, they put me in my room, and I thought it was my own room. But...I was put in a shared room. And I'm like ok, I'm gonna go in my room now because I don't want to be out here with all the crazy people. And then like there was clothes there and I'm like oh this must be my clothes so I put them on. But they weren't my clothes. They were my roommate's clothes. And he was really pissed...And I remember him bitching about it, and I was still completely out of it. I was not bothered by him whatsoever. I was like, why you so angry? I was very Zen-like in my psychotic state, I wasn't like, it didn't click to me to feel ashamed or bad about any of it.

The process of Doug's entrance into the asylum begins with him being strapped to a gurney inside an ambulance, so he has little movement in any of his limbs and can securely be taken to the hospital. He is then stripped of his clothing and given the hospital uniform to wear, symbolizing that he is now an inmate (Goffman, 1961) and, due to being involuntarily committed, cannot leave of his own free will, as the law allows (Légis Québec, 2018). Doug's narrative first includes fear of being contained and placed in a very startling and unique setting, but that fear is then quickly displaced by the "Zen" feelings he was experiencing from his psychosis. His lack of awareness became pragmatic in some sense, as he was able to resist conformity to some of the ward rules such as not leaving or wearing other's belongings. At the same time, the peaceful aura he carried also helped him remain compliant and non-aggressive. Usually inpatients are dichotomized as compliant or unruly (Canova Mosele et al., 2018), but Doug's mental health and institutional experience interacts on a complex spectrum of control, unawareness, resistance, and conformity.

While his roommate was upset about him wearing (and stretching) his clothing, Doug's illness also gives him a mysterious sense of closure. What are we to make of the Zen that Doug describes? Some psychological literature correlates religiosity with mental disorder (Bonelli & Koenig, 2013; Park et al., 2012). However, this narrative demonstrates that religion clearly has some positive implications for mental health, and can help one sustain their life in times of peril (Behere et al., 2013; Levin, 2013). The blame and hate thrown at him, which he became used to in his everyday life, was deflected by the sense of awe and enlightenment. Even during containment, there was peace in madness, and this serenity helped him escape some of the pain of institutionalization. His more superficial connection to the world was being replaced with a spiritual growth he closely identified with Buddhism, which is similar to the experience I had with a deity when I thought that my life had come to an end. It pushed me to continue trying to survive and gave me hope even in the throws of psychosis that my circumstances would eventually come to an end.

Doug: I think my states kind of fluctuated between paranoia and a very Zen-like state. I think my second time being hospitalized for a psychotic break, I spent a week basically, I think the best way to describe it is I was basically a living Buddha. Like I actually, I felt at peace with the world. I know that even she made the remark, my psychiatrist, that I was some sort of exalted religious being. That's how I was acting, like Ghandi would or something. Because I was living that. And it didn't feel just like some act, like I really felt just at peace with everything and I spent like a week like that. But I also was refusing to eat, so I didn't eat for an entire week, because I was on hunger strike, I was not gonna accept their dominion over me.

Not all madness is bad. Doug describes here a meditative and relaxing state of consciousness brought on by psychosis, one that was spiritual to the extent that he could cross the borders of war and tyranny in the world and in the asylum, and was able to develop a sense of peace with everyone and everything around him. In a dark, closed off area where mad people are kept, he was a living light who had the privilege of experiencing feelings most do not in the

everyday world. His containment and affliction created or revealed something in him that countered the chaos, family insecurity, and troubled relationships that started his slide away from stable mental health.

On the flip side, Doug was still resisting elements of the psychiatric apparatus. He went on hunger strike as a way to passively resist some of the control mechanisms of the ward. While still at peace with his situation, he had knowledge that the purpose of his confinement was to exact a “dominion” over him, and he was not always in agreement with this strategy. Of course, while there is always resistance to power, there too is retaliation against resistance.

Doug: At the end of the week, six nurses come into my room, turn me over and jab a needle into my ass. But after that I was hungry and I ate. That was their only concern, was that I eat. But then like that whole feeling of euphoria just disappeared obviously. I knew at one point in time they would get a court order. And that’s what they did, they got a court order to like force that on me. And I told them that when that time comes, I would not be violent, I would not resist you...but I would not help you either. Just like a very passive, non-violence type of thing. And I think that at first like, they got like six nurses, like male nurses, to come in my room and like hold me down and flip me over onto my ass so they could jab it into my butt. But like I didn’t resist, I didn’t fight them and I think that at first they were all very apt because like you could feel that tension, like oh no if we’re gonna do this, is he going to fight, they were very on edge but when they realized that I wasn’t going to fight or struggle that they kind of like, they you know calmed down a bit. It wasn’t a terrible experience.

As many in-patients do in Canada (Dumais et al., 2011; Johnston & Kilty, 2016), Doug experienced a chemical injection of medication at the hands of ward staff for not eating. Rather than physically fight off staff, Doug resisted by limiting his movements, thereby placing the entire onus of the restraint on staff. Resisting physically can give the healthcare staff reason to be more forceful, whereas passive resistance, in this case, fulfilled Doug’s message that he did not agree with their display of power, but that he also was not going to stoop to their level by using equal measures of aggression. The biggest loss, however, was

his spiritual transcendence, something that carried him through his incarceration and allowed him to experience pleasure despite dire circumstances. He describes staff as thankful and relieved he was not going to fight off the many intimidating staff present. Aside from being injected, Doug did not measure this experience as particularly humiliating or traumatic during his psychotic episode. In fact, he explains how some of his hospital experience was actually positive.

Doug: I actually ended up liking the hospital. I liked being there. Because I didn't have any responsibilities. Just calm and just chill out. Just read a book. But today I would tell you I don't ever want to go back. There is a power dynamic in the hospital and they do try and control and like, I'm not a fan of psychiatry. I have a bunch of like very conflicting opinions about psychiatry. I like being there but I don't like how it was handled with me personally but I can see how it is the best way they need to go about it or a good way to go about it with the majority of people. I don't think that I would qualify as the majority of people. Like food is how they control you and how they get you to do things. And the minute where you start saying I don't want to eat food, fuck your control mechanism, like I'm not bowing down to that, then they start to panic a little bit because their grasp on how to control you starts to slip...And my objection wasn't that I didn't want to eat. It was that, the food sucks...Like I don't want to eat meat. And when I started to realize how it worked...I had found a way to get out of that power structure. And obviously I wasn't causing any trouble for anybody. I was in my room reading books...I was even helping them, I wasn't like a problem whatsoever. But I refused to be governed by them.

Tensions resonate throughout this passage. Doug understands that hospitalization and even some elements of control are, to some extent, a necessary evil when people are faced with serious mental distress (Danzer & Wilkus-Stone, 2015; Katsakou et al., 2012). This is true even amongst concerns that involuntary hospitalization can have negative and long-term consequences on people such as stigma, self-esteem issues, stress, and even suicidality (Xu et al., 2018). But he does not identify as the typical consumer of psychiatry, and not being accommodated for his diet drastically diminished his opinion of medicine. In a later discussion, Doug likened the food-related control to police interrogation. He told me that when police give you chips or a drink to get you to talk, it is a similar privilege system to

what goes on in the hospital, where food can serve as an interruption in the monotony of the daily routine, and simultaneously helps him feel more like himself. In his case, not taking the reinforcement of food led to a conflictive position between him and staff, and because it was so unusual for a patient to refuse meals, his hospital identity created confusion, and finally a resort to legal means to get him to eat.

It might seem obvious that a more humane response would have been to find him some appropriate food, rather than engage in games of power. I had similar thoughts when the orderly decided to interrupt my bathroom session in order to confiscate my phone while my discharge papers were being drawn up. These experiences raise a number of questions. Why is a ward rule so important to enforce even if it removes the dignity of the patient, who because of their illness, is someone who ought to be constructed as someone who has done nothing or very little wrong? Are psychiatric wards on the verge of absolute breakdown and chaos if patients realize that some rules can be stretched? Why does resistance to what Holmes and Murray (2011) refer to as infantilizing control mechanisms have to be met with some extreme measures of power? Does a lack of rules and management techniques really make psychiatric wards that much more dangerous?

Still, being freed of responsibility and able to shut his mind off gave Doug some feeling of peace, and perhaps allowed his feelings of exaltation to emerge and develop. He spent a great deal of his time quietly reading and relaxing when he could. He saw these activities as helping his acute recovery, as it took him away from the pressures of life that helped cause his mental illness in the first place. He sees this process as beneficial for many people confined in hospital settings who may have little to no help outside of the formal system. Yet for people who are acutely aware of the power dynamics in the hospital, this

comes with the cost of knowing that one is a prisoner who is not-so-subtly being analyzed, moulded and eventually conformed to a certain setting. This is a knowledge Doug had to mitigate in order to eventually gain his release.

Doug: And like you know the hoops that you have to jump through. You can't jump through them too willingly. Like there has to be, it's strange because like, you have to make the psychiatrist or the doctors feel that they're the ones making you jump through those hoops and not you jumping through them because if you, you take too much initiative, then they like, it's like it's really a weird relationship, it's a weird dynamic. You're kind of like letting them.

In this passage, Doug states that recovery is about more than just playing sane, but that doctors need to be reassured that their treatment is what is the cure, and not the agency or self-healing of the patient. If the patient recovers “too fast” or “too much on their own”, it could be taken as a sign that the patient-doctor relationship and hierarchy is not strong enough, and that will undermine the milestones that need to occur for a doctor to be convinced in good faith that the patient is recovering. While there are many infantilization rituals that are imposed on patients in psychiatric settings, Doug recounts there being a need to patronize and even dupe, to some extent, psychiatrists into believing that their treatment, orders, and doctrines are what is most instrumental to patient recovery, rather than individual healing or some other mysterious force at work, such as a deity. What this narrative signals is a subtle conformity to psychiatric power where the patient simultaneously is able to feel in control of the dynamics vis-à-vis their recognition of what is going on (Canter, 2001). The doctor has to be convinced that their treatment is working, and that may very well be the case, and the patient has to also satisfy the authority of the doctor by playing along and acknowledging their power to heal them. Yet in *choosing* to conform to this relationality, even if perhaps for reasons pertaining to hospital release, Doug demonstrates his agency to declare that he is feeling better – a right he now shares in some sense with the doctor.

This reminds me of my own institutionalization, where the first meeting I had with my psychiatrist I noticed the keys she was wearing around her neck, and I took this as a sign that she was the warden and gatekeeper of the asylum. I played sane as best I could given the circumstances, which no doubt accelerated my release considering that when I left the hospital I still had many psychotic symptoms. In my second psychiatrist letter, following my release from the hospital, the doctor described me as not admitting to having other symptoms, and that I certainly did not present as having them. Indeed, it is the doctor's judgement that is omnipotent, and this occurs alongside the possibility that patients can, in some cases, choose to disclose or hide successfully some of their feelings and realities.

Hospitals, like any institutions, require that people live up to a set of dynamics and rituals to navigate life, gain status, and if necessary, stay safe. Doug recounts the fear of being placed in an institution with people he understood to be violent and aggressive.

Doug: I was in a better position than like the vast majority of people, the ward that I was in was with people who are schizophrenic and people who are very very Bipolar. And...all men. There was maybe like, the only girls that were on our ward were the really crazy violent ones. That...(laughs)...that you stay the fuck away from. And it was scary...they were unhinged but...they didn't try to obviously really like mess with the guys cuz still a guy could defend themselves. But they were not able to place those women with the other women because they were...it didn't work out.

Since the Ship of Fools, societies have dealt with those labeled mad by placing them all together, sometimes in very close-knit environments (Foucault, 1988). If women defied feminine norms by acting aggressive, they were placed in the male units, in hopes that men could defend themselves from such behaviour, while the women wards (in this case) were protected from such dangerous people. Generally, psychiatric wards become sex-segregated in order to protect vulnerable female patients. When wards become mixed, there is evidence that a process of positive development occurs, with female patients becoming more

externally oriented and motivating of others, and men becoming more modest and quieter (Krumm et al., 2006). What Doug describes above is a similar gendered process where women on male wards showcased their dominance by acting aggressive, but not to the extent that it materialized into violence. Aware of their potential for violence though, Doug describes men as relying on size, stature, and techniques of violence as a defense mechanism. The performances of gender, according to this narrative, are less overt and signal a subtle struggle for control in an environment where mental instability and illness causes concerns for safety.

Doug also describes a kind of mental status hierarchy within the wards. Those who are labeled as schizophrenic carry with them the greatest torch of stigma, and are to be feared the most during their delusions. Those on the spectrum of Bipolar 1 Disorder come next depending on the severity of their illness, and they are viewed as unstable enough to live amongst the schizophrenics. Elsewhere, Doug said that those experiencing Bipolar 2 Disorder (less severe) or Depression would be kept separate in the ward from those who hold a more treacherous label. There were, however, times when all patients had to interact with one another, such as mealtime.

Doug: The Zen state did not happen until I became like at peace with seeing violent people. Of course, for the record, I was crazy...I know it's a derogatory term. Like, I remember obviously, food you have to eat on the ward, you are interacting with people. At least three times a day. What happens is, if you want more salt, then you have to ask your neighbor if they're gonna use their salt. Or like, if you don't like the pudding, like chocolate pudding, then you trade it with someone else. That's, that's how it goes right? So you have to interact with people, and some of these people, they were not always good. They would get really angry at things sometimes like they would yell...but I learned pretty early on they weren't going to attack you or anything. They might be angry and violent and such...and they might even yell at you or whatever but it was...it ended there.

Doug's Zen state was triggered by being confronted by seemingly violent people in a setting where there was no escape, and so he needed to achieve a level in consciousness to be able to deal with that reality and conquer his fear. Like in a school or prison setting, people were obligated to interact when they ate, and he describes a bargaining system that was implemented in order to enjoy the food.

When things did not work out so well, and patients fought over trivial matters, Doug recalls that the situations rarely escalated to violence. What started as a fear of the unknown (that he could be attacked) turned into a comfort with the people on the ward who, while characterized as unstable, held boundaries in terms of how aggressive they were willing to get. That is not to say that people did not annoy him and get under his skin.

Doug: But one guy that annoyed me the most I think, he had Tourette's and they put him in the room next to mine...And...oh my God, he got under my skin but only because he was preventing me from like sleeping (laughs)...I'm actually kind of like thankful I experienced it because now with homeless people. That's...they're the same people that I was with in hospital. Like so...when I encounter like some homeless person who's like yelling or like talking to a tree or something. Like, it doesn't really bother me. Yeah. So I'm happy it gave me that experience because it allowed me to view the people that I would otherwise had written off differently.

As difficult as it was to endure life in the hospital, which sometimes resulted in a lack of sleep and comfort, Doug is thankful for being exposed to some of the issues people face. His fear of homeless people was replaced with compassion – one that was heavily internalized and blossomed out of being reflexive about his own situation. People Doug might have discarded in society became his comrades, and he started to view experiences of auditory hallucinations or talking to objects as not always-already bad. That is not to say that he views these sometimes temporal experiences as unsickly, as some scholars or Mad activists try to position in certain circumstances, spectrums, and thresholds (Rashed, 2019). But Doug's relation to the Mad and homeless allows him to no longer experience fear, disgust, or shock

when being confronted with a body and mind that does not fit with what we are used to seeing.

Doug recounts another moment when someone thrown in the pits of madness encountered something beautiful.

Doug: One of those really violent girls, like short hair, wanted to like kill everybody. She was an amazing violinist. And one evening they let her, her parents came during the visiting hours and they brought the violin, she like played really really really well, like for everybody. And, it was really nice, so like that was one instance of someone's like...something good and positive, something that is like hidden beneath all this crazy bullshit that's happening. And, and everybody, well not everybody, like some people...but you know most people like have some sort of skill or like they did something.

As explored in the previous chapter, art shows up in Doug's journey, too, providing a temporary escape from the pain, confusion, and hostility. The institution was responsible for creating a space within the asylum that, rather than facilitating the assertion of control, power and coercion, empowered and soothed observers (Bauer et al., 2010). Staff members themselves are human beings who make errors and sometimes atone for them (Khatib et al., 2018), and this opening of a music space worked to humanize both the dehumanizers and those who have been dehumanized in one setting. Mad bodies likewise came together to experience a transcendent beauty in the form of violin music, and this experience reshaped how Doug perceived his fellow patient. He realized that beneath the pain lies hidden talents, ones that he feels all people have, even if suppressed by the exertions of life; struggles, as Doug goes on to describe, that can stay with us for the remainder of our lives.

Doug: A beautiful word in French, they call it *séquelle*. Scars but like lasting injuries that happen and stay with you the rest of your life. Like this and my wrists...that's *séquelle*. And I feel that although they're not, like, impacting everyday they're still there and they still I would say affect what I can do and what I can't do...I think that it has impacted really my ability to like form friendships with people and...have friends. It is unfortunately very easy...for me to shut people out of my life because, I've lost friendships...I had like a best friend, like were best friends for like 25 years

but at one point...in part, I would say mostly due to my illness, like frustrations, and I was not a pleasant person to be around, I was an asshole...it seemed that one by one all the people that were close to me like distanced themselves from me and pushed themselves away from me, or just...completely shut off the friendship. And...I got used to that...it's almost normal that it happens like that. Um...but as a result it's really hard for me to connect with people and...care about them. Sounds like a terrible thing to say but...I want to be a good person and do my part. Be a positive contributing member of society. Like these are goals for me...but like I don't want to deal with people on a one to one individual basis. Stay the fuck away from me.

I notice the scars on Doug's arms and I think about my own brain. I picture a cut along the cortex pulling me further away from who I used to be and pushing me farther into who I am now. Some scars mark our bodies, while others fester from the inside. In this case, Doug carries both the physical and mental weight of his illness. The shaking the medication gives him, the cuts on his arm, and the social isolation his Bipolarity imposed on him, mark him forever. He cannot make long-lasting friends and connect with people on an intimate level, and this caused him to withdraw and distance himself from other people. How others see him is different from how he sees himself, which even most days he is still trying to make sense of. When I asked him if he experienced any regret about the people he hurt during his illness, Doug relayed all the efforts he has made to try and recover and move forward.

Doug: I did blame myself for a long time. I didn't accept who I was. I would try and hide...But recently, no I don't feel that anymore...Like I did a lot of fucked up shit...if you end that thought there, then the shame and anger will stay with you. But like I've done a genuine effort to like understand what I did, how I did it and how to avoid doing that again in the future. And by doing that, and by taking that tragic or those bad events and by turning them into a learning experience and applying it consistently in my life today, I don't feel ashamed about those things. I'm apologetic like I'm sorry that those things happened to others, like I'm not angry at those people or those things and I don't blame them for being upset at me. But I don't, I don't carry that with me anymore. Like if they want to choose to still be angry and upset about those things, that's their problem, have fun with your anger. That's not mine. Like I...fucked up I made a mistake and I did these things to correct it, I don't make that mistake anymore, what more can I possibly do? And the answer is nothing, I can't do anything more than what I'm doing right now.

Mental illness can strike anyone. It can torment individuals daily, destroy families, ruin friendships, and cause others to never feel the same again. What Doug recognizes, though, is how hard he worked to bounce back from the person that the affliction created. He knows how to live in the midst of mental pain and yet not make the “mistakes” he made before *because of* his anguish. He does not need to feel ashamed, he does not need to regret his life, he does not have to hold onto the lingering memories of the past, but rather stays strong in his ability to keep moving forward. Others who he hurt may not know or see their pain reflected in this light and inspiration, but for the purposes of living a manageable life, Doug accepts that he has done everything possible to be the best person he can inside a painful mind.

Finding ways to cope, of course, is easier said than done. For Doug, simple and minute improvements add up to significant changes over the course of time.

Doug: The most important thing that people just try and do like 0.01% better than what they did the day before. And that’s the pretty general rule you can apply to anything. If you’re 0.01% better is like, getting up at 1:30pm instead of 2:00pm or...1:45pm, then do it. And if you keep doing that over year or two, like maybe you’ll be getting at 8:00am quickly every day and not having that issue. I think that...it’s kind of like, reducing...I don’t want to say reducing, I think that it’s more like...breaking apart your goals into the smallest possible unit and focusing on that smallest possible unit, and not the goal itself. Because I don’t think it’s reducing your expectations, I don’t think it’s diminishing them, I think it’s looking at the small possible increment you can do everyday...Like you’re not even gonna notice doing it.

Drawing on some of the underpinnings of cognitive behavioural therapy, Doug fights his battles in increments. If the micro challenges of the everyday are conquered one step at time, then the macro challenges such as altered identity, a loss of meaning in life, or reckoning with long-lasting injury, will slowly be overcome (Newman, 2016). While he acknowledges that mental illness positions people in a space where there is a need to crawl back to reality,

self-search, and re-gather the things that were lost, he also describes how there is always something to be gained from madness.

Matthew: What has this given you though that you don't think you would have now...if you didn't go through mental illness? What's the gift from this?

Doug: To be able to think abstractly (laughs). I remember during my first break I was like sitting on a bench and I completely disassociated from everything like...like the bonds that held reality together, like I saw them in my mind disintegrate. Nothing meant anything and anything meant nothing, you can abstract any meaning to anything...I remember that moment and I was like...this, this, this realization does not happen [to people] who do not go through [this]. Like it...it's hard to describe...it gave me a perspective that, like, most people just never would even...But to live that...it's...it's different...It's like the bonds of the universe revealed themselves to me...completely changed how I thought and I have perceived the world...And uh...it has served me well I would say in academia.

Although the pits of madness led to Doug's institutionalization, a loss of friendships, chaos in his family, and experiences that would haunt him over many years, he takes from all this a gift—to see what others cannot see. He illustrates a cosmic bond shared by those who experience psychosis, an ability to understand and experience literal and ultimate truths, knowledges that are otherwise irreducible from rationalist thought. He has used this ability and memory to continue thinking critically and abstractly, as evidenced by his growing affinity with academia and graduate school. The experience of madness has helped him to achieve a future he could not have obtained before he developed adequate coping mechanisms and recovered.

The Western colonization of madness by the psy complex has led to the suppression of buoyant mad identities (Miller, 2018), and the denial that some illnesses, while producing pain and grief, can simultaneously bring out “gifts” (Farber, 2013) in persons – hidden talents and ideas that otherwise would be unknown if life was confined to sober consciousness. What is lost when we do not incorporate these understandings of madness into how we

respond to mental health struggles? Would Doug have been comfortable sharing these insights with his doctor who was in charge of ensuring his stability? When we deny such a reality and overlook these emerging identities, that dreadful experiences of psychosis can in fact contribute to knowledge, the mental health service user is reduced a sickly perception and we miss out on details and lived experiences that help us transgress mundane, everyday thought. The stakes are certainly high, however, I suspect few people would be willing to go through a psychotic experience to learn about metaphysics. But there is a need to acknowledge the gift of madness beyond mediums of art that mad people must resort to in order to capture such experiences. Doing so in everyday conversation and clinical settings might help us mobilize the gifts of mad people and make sense of their pain in a way that is empowering rather than solely pathological (Tenney, 2016).

Although some abilities and skills emerged for Doug, it is important to consider how others have been dampened. Although Doug can think in academic terms more strongly, he did experience a profound change in his creative impulses since his recovery.

Doug: I used to be a lot more artistically driven. Uh...I used to write a lot of poetry and all kinds of stuff. I used to play like guitar and all that. But I dropped all of that. I think that's probably the kind of thing that would be good to mention, I feel that this ability I gained now. Although, perhaps...not a necessity I did abandon and distance myself from all creative things and that side kind of died...I think it still exists, I think maybe more writing my thoughts and how I look at the world. So I don't want to say it's dead. But it has shifted into that, instead before it was very easy to see and now the only time that I, I think I wrote one poem last year and I was really drunk and angry, and I just came out like that. It seems to me the only time I can kind of elicit that creative impulse or draw it out is with the help of alcohol and suffering. But I've, I feel that I've like come at peace or I'm ok with the suffering so I don't have that urge anymore to like outwardly create something from that...I feel you have to suffer, I feel that there has to be some sort of torment. I just don't feel it anymore.

Where there is loss, there is gain. Art was there when Doug needed it to be there, but after having achieved peace with his suffering, this gift has moved on, to find another broken soul

and help them make sense of their mental health. And he does not miss the emotions needed to activate it, because he is better now. He is drawn to other inspirations.

### *Jermaine's Story*

When I first met Jermaine, a younger Black Canadian, I was somewhat taken aback by his friendliness, warmth, and sense of humour. His story is one of acute survival, struggle, and resiliency, and he made sense of his journey in a way that created both laughter and tension. When he tells me, before the recording starts, about the many jobs he has worked, I am intensely aware of my own privilege, knowing that his socio-economic disadvantage and racialization surely contributed to his great pain. He begins his tale by describing his experiences in childhood and how drug use became a way for him to fit in and then a crutch, before moving to a Canadian city where he had difficulty landing permanent work.

Jermaine: It started as being a kid, it was an introversion thing, in and of itself isn't a mental health problem but it was being introverted and keeping to myself a lot...and it's almost weird to kind of blame weed but I remember I started to smoke weed when I was 14. Which looking back really accelerated this kind of like anxiety and depression thing. So to fit in with people I was smoking a lot of weed...I did my undergrad in [Canadian city]. And...it was a small town thing combined with um...there wasn't a lot to do. The drug use kind of accelerated, and it was like harder drugs...like going to the pharmacy and, like you know Sudafed and these kind of things. But I guess it was, even before undergrad it was an anxiety driven thing...like a paranoia like what people were thinking about what I said...But then what happened was, this is where it really went downhill was, I lived in this house...with these two sisters. Actually around this time I wasn't doing much drugs, I was drinking a bit. They were doing whatever. And then I was doing freelance work which...all kinds of dried up simultaneously, it was just one of those coincidence things. Then I got broke. Then I couldn't pay rent. Then what happened I got...uh...well, the stress. So I stayed awake for a week or so. I couldn't sleep. Then I started to hear um...there was voices that I was hearing. There was no visual hallucination.

A growing body of evidence suggests that there is a link between cannabis use and psychosis, and illustrates how drug and alcohol use can reveal pre-existing mental health vulnerabilities (Gage et al., 2015; Hamilton et al., 2015; Hamilton, 2017). However the literature cannot

determine if cannabis causes psychosis, or if it helps trigger and bring out pre-existing mental illness that could have been caused by, say, childhood trauma (Houston et al., 2011; Murphy et al., 2013). In my own experience, one of my psychiatrists insisted that my cannabis use was heavily related to my psychotic episode. While I did not feel comfortable or safe refuting his claims, I know my mind unravelled because of my growing isolation from peers and family, the stress of my committee and doctoral program, and a growing paranoia that people around me were not looking out for my best interests. I concede that cannabis might have impaired my judgment and ability to think clearly, but pinning my issues on cannabis use when I had used the substance without much issue for years prior to my psychotic episode seems a bit odd and reductive. It is also peculiar that I had a second psychotic break having been substance-free for several years.

So what place do mad people have to share insights about the causation of their pain – illnesses that because they occur in the brain are incredibly difficult to pinpoint their biological origin? Jermaine identifies his cannabis use as instrumental in heightening his depression and anxiety symptoms, but it also interacted with his spiral into social and economic disadvantage, which is when the psychotic symptoms started to emerge. Locked out of his apartment by his roommates, with little familial or other resources available to rescue him, Jermaine began sleeping at a university campus and using their facilities as refuge.

Jermaine: I stayed awake for a week out of stress, but then it hit me that I was you know, I was starting to hear voices, I remember someone was saying my name, and I remember I looked in every single classroom and there was nobody in this building except for me. I was actually sleeping a lot at [university]. Because you know there's no real like, there's security guards but, the classrooms. And then when I finally said ok I got to go back to this place and get my stuff, I got locked out. And they were like, 'yeah we're not giving your stuff back'. You know... 'you disappeared'.

The spaces that surrounded Jermaine played into his delusions. What began as an opportunity to have shelter when he ran out of money, turned into a space of distant and surreal voices. Jermaine had to be on guard to make sure security personnel or night janitorial staff did not interpret him to be a non-student, lest he be trespassed and forced onto the streets. Having to watch his back most of the time, trying to find a way back into economic security, and dealing with the stress of being kicked out of his previous apartment heightened his paranoia, and triggered the beginnings of his psychotic break. To help cope, Jermaine started drinking heavily.

Jermaine: They call this 'homeless people wine' because it's like cheap and it gets you really drunk or whatever. So...I was drinking a lot of that...while not sleeping, and basically not eating. It's like you'd think at the times, you'd scrounge up change to get some food, I was eating here and there, but it mostly like I was drinking, the drinking is gonna get me escapism, right?...I remember I'd be walking, you know that bridge by the [sports arena]? I remember walking by that bridge and having this impulse to like...I walk across this bridge, either I'm gonna jump off or whatever. And I had many incidences...But yeah I was becoming homeless...In the end I was homeless for six months.

Sinking deeper into a hole of poverty, substance use, and mental distress, Jermaine contemplated suicide a number of times to escape his pain and misery. This thinking process went on for a number of months, but still Jermaine found enough strength to continue to survive in precarious and dire circumstances. He discovered a number of ways to occupy his time and create meaning when there was little given to him.

Jermaine: And then I was like rolling...this thing that we call buddying. Just like you go and find cigarette butts and you roll them. And because there's so many smokers on this campus, thousands of people smoking. So I'd never...it's like all my vices could be...maintained, and it gave me a sense of like...doing something, like ok, today I have to get butts. So it's like...you fall into this routine of um...you're doing these things that don't mean anything but they matter to you. And so...I'm living on campus...I'm somewhat maintaining, I'm not like starving, I think the booze calories were probably helping a bit, but I definitely was, like I would spend entire days just hitting on girls at [bridge]. It's like...this whole time I was convincing myself that I'm not good enough, or you know, I'm too good for OW [Ontario Works], which is

the social welfare or whatever. This is what I'm telling myself even though it's like a delusion of like, I'm fine. And I think it's because it was summer.

Jermaine focused on everyday, simple comforts to get him through a tragic period in his life. While not necessarily proud of these actions, Jermaine frames himself as feeling above needing to access social welfare to meet basic needs. Resisting and finding a way to survive outside of the public system gave him a sense of accomplishment, but one which he eventually came to feel was the result of a distorted sense of thinking after he finally reached out for help.

Jermaine: So I eventually locked myself into the social assistance office, and told them the whole story. They're like yeah you can't keep going on like this. And I hadn't slept in a while...I told them look, I'm hallucinating, I'm having these replays that are overlapping with my reality, so I don't know what's going on...I think it was one of those, you're holding on by a thread kind of thing. I don't think that, if it had continued a month I would be either a) be alive or...cuz another thing that happened is I caught...meningitis towards the end. I tied it to the rolling of the cigarette butts cuz...There was no other like, real contact with people...But when I went to the doctor, they did the tests, he's like 'first of all you have meningitis, second of all, I haven't seen a case of meningitis in fifteen years'. And then he's like 'how long you been feeling sick?' I'm like 'two-three weeks,' he's like wow. Like people don't...I guess meningitis is something you can die from pretty easily. I didn't know anything about this. So when I look back there's like a lot of things I dodged and survived. I don't think I would have lasted a winter.

Desperate, Jermaine confessed his situation to doctors and staff at the social assistance office. Beyond hearing voices, he started to remember events that did not happen. For instance, he told me he would call friends and mention a conversation they had had, but they would confirm to him that it never occurred. While he believes that the heat of the summer months helped him survive, his narrative also points to an impulse to keep pushing forward, despite abject circumstances. He previously denied monetary assistance, but his class pride gave way to his pain, and he reached out to healthcare professionals.

The family support however was not there for Jermaine, and since he was quite isolated and often unable to seek help from others on a consistent basis, he had to focus the brunt of his attention on trying to stay sane and rest in a declining mental state. The answer one of the doctors he saw was to give him a prescription for a drug infamous for its sedative properties.

Jermaine: They're like ok...we're gonna give you Seroquel...take 25 miligrams of Seroquel...if it doesn't work we're gonna give you 50. So I took 25 and still stayed awake. Then they're like, ok 50...when I started to do the 50 was when I got into these rooming houses...so I guess the social assistance, the welfare office has it set up that, the rooming houses take some of the burden off of the homeless population by just housing people regardless of what their issue is, mental health, addictions or whatever. They can live for like 400 dollars, I think I was paying like 415 for like a room that had no fridge, that had no heating...there's rats. The rooming house was like...that's when it really set in that yeah, my life has kind of spiraled out of control.

To treat the plethora of issues Jermaine was facing – insomnia, auditory hallucinations, socio-economic crisis, substance abuse, and a lack of family and peer support – the doctors thought it best to put his worries to rest by prescribing him a powerful sedative.<sup>5</sup> The problems he was facing were psychiatric, social, and economic, and as a result Jermaine was in contact with both social workers and doctors. However, the response was inadequate on all fronts. First, we see how the state takes its responsibility to house its unwell citizens with a lack of commitment and honour, and in turn, the medical establishment neglects to identify serious mental disorder and how its causation is related to social and economic circumstances (Mills, 2015). Both the state and medical apparatus work together in this narrative to put on

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<sup>5</sup> One report confirms that some people in Canada prefer homelessness over rooming houses because of their dank conditions, including insect and rodent infestations, carelessness on the part of landlords, uncleanness, and dangerous tenants (Somerset West Community Health Centre, 2010). One woman claimed that sleeping on the streets was better than rooming houses because she was concerned about others constantly using substances in front of her (Karabanow et al., 2010)

band-aid on Jermaine's deteriorating state, and through sedation, heighten the chance that Jermaine will stop complaining about his situation (see Kilty, 2012).

Jermaine goes on to describe in painstaking detail how living in community housing affected his mental health and interacted with his delusions.

Jermaine: It was never cleaned. So there's a kitchen and the garbage never got taken out ever. Nobody would take the initiative. I think people were like, it's not my job...it wasn't like a dorm or something where it's like you're chipping in or anything. And there were so many rats in that building. You'd get bitten at night, that was another thing...I first lived in one rooming house that was maybe eight people. But there were, they would be smoking crack in the building. Drinking all the time. Cops would be showing up, and bed bugs...so...I was prescribed 50 milligrams of Seroquel, I passed out. The first night. And then the second night I started to notice the bed bugs and then I didn't sleep for another four days...I would take [Seroquel], but when I realized that there were bed bugs I guess for some reason in my head, I was like I can't sleep. Yeah, so it was like, I was just in this weird state of being high off the Seroquel, and then being paranoid of bed bugs.

Jermaine was now experiencing hallucinations related to his stress, insomnia, and persistent paranoia over bed bugs and rats biting him at night. Substance use was rampant in the building, and attracted police presence, and he did not feel that the place was much of a community, as one might describe their neighbourhood, suburb, or dorm room to be. All Jermaine could do to cope was sedate himself with the medication the social assistance office provided him – up to this point, he did not have a diagnosis or any kind of stable recovery plan. He was still working freelance work at a radio show on and off, but as his mental state and material circumstances declined, he began missing his night program due to a lack of sleep, and other members of the radio show began noticing how he was using the building as a crash pad.

At one point, Jermaine got the strength to try and live elsewhere, wondering if a slight improvement in his living scenario might catapult him in the right direction.

Jermaine: ...eventually I moved into another building. I told them look I can't live in this place. They sent me to another building which on the surface seemed, it was a quieter, there was no more crack smoking or whatever. But there were rats, so every night I'd get bitten. Or I mean, I couldn't really say every night, but I definitely woke up multiple times sore. Yeah you'd wake up to like what the hell is that. The very first night I slept, like something kind of like bit me. I'm like...ok. And then I look over and there's like a rat taking off or whatever. And I'm like wow. And this happened every week. Sometimes you'd just be...you start to develop this like you'd see out of the corner of your eye is that a rat? And there's nothing there. You know what I mean? So it became almost that hallucination thing over and over again.

Jermaine described earlier a heightened sense of paranoia intensified by the fear of being bitten by bed bugs. Now a recognized phenomenon, research is beginning to establish a link between bed bugs and psychosis, paranoia, post-traumatic stress disorder, personal dysfunction, nightmares, hyper-vigilance, insomnia, and anxiety (Goddard & de Shazo, 2012; Rieder et al., 2012). What is evident here is a vicious circle of mental illness and pain proliferated by the trap of social assistance and the psy/pharmaceutical complex. Jermaine continues to enact his capacity to get help, but no matter what intervention he encounters, his situation continues to worsen.

Specifically, his hallucinations were becoming visual as he began to see rats that did not exist. His sense of reality was deteriorating in terms of what rats were real and unreal. Since some of the rats were real, as evidenced by the sores he would wake up to when being bitten over night, it was hard to shake off his delusion. At the same time, he was trying to drown out the voices he was hearing by getting more sleep. But to sleep, he needed to take a sedative, and doing so made him more vulnerable to the lurking creatures of the night. Not everyone, as we learn, can survive the trap of these circumstances.

Jermaine: So then there was the day when this guy, um...I was going to this shower on the ground floor of the rooming house. It smells. There was a smell. And as the days go by...the smell's getting worse. And the way I describe it to people it smells like basically, a lot of brussel sprouts and eggs that had been sitting there forever. So I remember smelling it and being like ok whatever, this is garbage. But then the

garbage got taken out. Because we complained to the rooming house office...People were walking by the house and being like...it smells...so I called the fire department...they show up...when they're showing up, they're like, what room does he live in? He lives in that room...And then they kicked it in, the smell that we had before it was like times 100 when the door opened...one of the fire fighters is like yeah...and then the cop shows up at the same time. And they flashed a flashlight in, and the smell was just so bad and then...they literally took off. They just took off and like ran away basically...and then the coroner showed up. And so this guy that had been there for a week and so on and I remember thinking like, I've been living in a house with someone who's dead. And I've been smelling it, and like...showering, feet away from this guy.

Jermaine's embodied encounter with the sickening stench of death, and the realization that his neighbour could lie dead in his room for days without anyone recognizing it, both shocked and repulsed him. Police and fire personnel, after seeing the man lying there dead, did not comfort the community members but rather left the clean-up to the coroner's office, and then went about their other duties. Destitute and at his wit's end, Jermaine extended his cry for help by going to the hospital, to see if emergency services could rescue him from the waking nightmare his life was becoming.

Jermaine: First I went to the hospital thinking that they could help...So I walked to [hospital]...I remember I got there specifically at like three or four [in the morning]. And I was telling them I wanted to kill myself basically. And they're like 'Alright sir. Sit in the waiting room'...my thing was, in my own head I envisioned getting into the [psychiatric hospital]...I didn't see anybody until 11, 10, something...At which point I had already passed out in the waiting room. Then they're like 'ok sir, come in'...there was like this male nurse. When I told him...he was like a very straight faced...I think maybe they're probably trained that way, to not react to your story...I told him...like I thought about jumping off bridges every single day for the past however many days, or weeks or whatever...And then he's like 'alright, go down there. Follow that line and then go into that room.' I was thinking there was another waiting room...I go in...I walk in...I and I think it was like first I look around and it's all grey and then the door like basically shuts or whatever. And then I hear beep beep beep and I look back and there's no more handles, there was no door handles and I'm like, this isn't good.

Jermaine felt that being hospitalized in the city's largest psychiatric hospital would be better than continuing on living in his decrepit and dangerous residence. To get in, he needed a

doctor to refer him there, which is why he travelled to a local hospital, intoxicated, struggling, and desperate, in the wee hours of the night. While his story might stir many emotions within those who are unfamiliar with such stories, similar narratives are all too common to many frontline caregivers, and hence he was treated with neutrality when he told a male nurse the extreme danger of his situation. Confessing his suicidal impulses bought him a ticket into the psychiatric emergency department nonetheless, and when he heard the clicking of the doors closing, he knew he was somewhere quite different. Locked inside, he felt uneasy about his confinement and began questioning whether this was truly his best option. Jermaine goes on to describe his short stay in psychiatric-emerg.

Jermaine: And there's like this nurse behind like um...I don't want to call it bullet proof glass, she was behind something. And she was friendly...I remember what stood out was like the other people there were Black...they were both like immigrant sounding...everyone had a bib on or whatever, and one guy was like ranting. Like so much, to whoever was there. Some kind of psychiatrist or whatever. And I'm like oh boy. And they're like 'wear the bib and go inside the room' and I sat inside this cell basically. The steel toilet and all that. Then the doctor comes in...what I did was told him the whole thing. And he's like 'sounds like your problems are mostly based on circumstances like money, specifically'. And I'm like...because you're trying to summarize... for some reason I thought I was on a timer so it was like I didn't tell them that my whole life has been filled with...this anxiety. There was a suicide, I haven't spoken about that, a suicide attempt. There's multiple like, there was one actual attempt when I was 14...so I'm telling him like 'look, I wanna get into the [psychiatric hospital]'...I remember specifically he said 'you're too young to be sitting there listening to like...a schizophrenic person...rant to themselves at 3 in the morning and you're trying to sleep'. I remember thinking like...I still wanna go...And he's like 'you don't want to do that,' and then that's when they released me, gave me bus tickets, and then it was just...that's when things really spiralled. That's why kind of looking back it's almost like I maybe should have been in the hospital.

Left with no medication, no diagnosis, no social worker or follow-up with services that could help him financially, Jermaine was turned away from the mental health system at his lowest point in life. He wanted help, but in an underfunded system overloaded with patients, there was little help provided, with the exception of a courtesy ride back home. Inside, Jermaine

was surrounded by other people of colour that night, leaving us to question the extent to which racialized bodies are disproportionately likely to wind up in emergency services, especially if they are disadvantaged economically or if their problems are more likely to be psychiatrized (Nelson, 2016; Vige, 2005).

Jermaine describes feeling as if he had only a short time to summarize his issues to a very busy and time-deprived psychiatrist, a situation which he feels contributed to him not being hospitalized. He laments that if he had talked more about his suicide attempts and revealed the very traumatic and painful events of his life, that it would have proven to authorities that he was indeed unwell enough to warrant hospitalization. His story is framed as a lost opportunity, when in fact it was a failure of the mental health system to act. Rather than meet the needs of an intoxicated, suicidal and desperate man seeking refuge in the hospital, staff likely judged him as a poor Black man trying to get a clean bed.

This experience begs many questions. First, would a white middle-class person in a similar situation be dealt the same treatment? Mad people of colour are usually caught in a catch-22 when it comes to their experiences with mental health services. When they want to voluntary access services, they often find themselves being denied by healthcare agents more than white people, and at the same time, they are disproportionately psychiatrized for problems they do not feel should always come under the medical gaze (King, 2016; Metzel, 2009). Mad people of colour likewise have found their concerns and perspectives set aside by mad, white, middle-class people (Gorman et al., 2013), and thus it is important for any analysis to be intersectional. These impulses in psychiatry and representations of psychiatry are racist, and should not be overlooked.

Metzl's (2009) study about schizophrenia claims that the diagnostic category of the illness is a racialized disease that selectively focuses on Black men and invokes notions of violence and dangerousness. In this case, Jermaine's psychotic symptoms were responsabilized as more of a moral, employment problem, and interacted with his lower-class status. While he did not undergo the labelling that many Black men encounter when in mental distress, his racialized and class status caused him to be seen as more of a nuisance than problem to be solved in the mental health system. Compare his situation to that of Doug's, a white middle-class service user, and it is easy to see how differently mental distress is embodied for racialized minorities than other groups (Keating, 2015).

Second, how do these events deny Jermaine's agency and rights to make decisions about his health on his own behalf? On the contrary, was the psychiatrist saving Jermaine from the pains of institutionalization – pain he may not have been aware of given that he had never been hospitalized? Psychiatrists have to make tough decisions about who to admit and not admit to the hospital in an overburdened mental health system. But Jermaine had communicated quite clearly significant mental health concerns such as psychosis and suicidality which were dismissed as socio-economic issues – issues that the psychiatrists had no solution for except to send him on his way and wish him good luck. Had he been hospitalized and had access to a social worker, who often work in psychiatric emergency departments alongside nurses and doctors, would he have been stabilized and guided towards more secure work, housing, and a means of livelihood? Could they have helped him deal with his substance use issues that were contributing to his deteriorating state?

It is interesting that the doctor saw Jermaine's potential to be subject to another patient enduring auditory hallucinations and interrupting his sleep as a worse option than

trying hospitalization and seeing how he responds to in-patient treatment. Even if these measures can be coercive, Jermaine welcomed them because he felt he had no choice (Katsakou, 2012). Jermaine's narrative strikes at the heart of tensions related to involuntary hospitalization. While involuntary hospitalization may be necessary to treat mental illness, especially in the short term, acute phases, and prevent patients from harming themselves or others, hospitalization is also experienced as a demoralizing violation of their rights that may lead them to disengage from further professional help and, quite cyclically, risk re-hospitalization (Danzer & Wilkus-Stone, 2015). Yet what about patients who want and need access to this help but there is just simply no room to treat them?

Travelling back to the social assistance office and still in search of adequate help, Jermaine continued to reach out to more doctors and question their treatment plan. At the same time, he constantly battled with the ever-present option of taking his own life.

Jermaine: So then at that point I told the doctor like...this Seroquel business I can't continue with this. And I remember there was this bar hanging from the room, it was right across the top of the ceiling or whatever. And I remember thinking like alright, this is the day...And it was like so loose I can't...hang myself from this. Then...another day I bought um...so at this point I had graduated to drinking...this wine called Sola which is like...you get it at wine rack. And it's like 17-18 dollars for like almost two liters or something. So I would drink a lot of that...there was a point where I didn't take a month's worth of Seroquel. I think that I had been over prescribed so I had two bottles. So I remember thinking like today, I'm just gonna drink, I'm gonna down these two bottles of Seroquel and then drink the wine. I'm like there's no way that I'm gonna live through that. And I was like pacing up and down, walking from one end of the plaza to the other. As I'm coming back, there's a Winners and like my friend and his girlfriend come out and I remember being like oh...like they had no clue what's going on. Well maybe they did but, they're like yeah 'what are you doing man, wanna come over to our place?'

Here we encounter a narrative of chance. Had his friends not asked him to come over to their place that day, Jermaine is certain he would have attempted suicide again. He managed to survive psychotic hallucinations, meningitis, suicidal ideation, rodent and bug bites, severe

substance use, homelessness, and abject conditions of poverty, mostly without the aid of professionals. Like Doug, Jermaine is highly agential in that he continues to demonstrate his potential to engage in rationalistic decision-making processes in a deluded state – decisions that swing back forth between ensuring his survival and ending his life pain once and for all.

Yet no matter what he tries, his circumstances recycle themselves as he is ensnared in a cycle of disadvantage and repetition. Then one night, after an incident with sleep paralysis and what he believed was a near-death experience, Jermaine was triggered to make drastic changes to his life.

Jermaine: The beginning of December I was sleeping. And I remember I woke up...you know when the room is dark but when you wake up and you can't necessarily, you can't see everything at first. But then you can make, like I was able to make out the outline of the door frame or whatever. But then I couldn't breathe. And I was like trying to like get my breath. I think something in the ballpark of what I understand as sleep paralysis or whatever. Couldn't breathe, gasping for breath, and then I remember like, the doorframe that I was able to see suddenly [went] out, it was fading to black. And I remember being like oh shit. And then...no that was the second time. The first time I woke up to myself throwing up. The second time was this thing I was describing. And I remember being like this has to be it. And then like I faced the black I guess I like come to and I'm throwing up again. And then I'm like yeah...a) I got to stop drinking, b) I gotta stop, um...I got to lose the weight, so 2016...stopped drinking and then just...went on this fitness thing which I became obsessed with. And that became like a new whatever. Like the obsession.

Jermaine's weight reached 300lbs, a combination of his alcohol use and the side effects of Seroquel, and he was beginning to feel the physical effects from this dependency. After a confrontation with the darkness associated with sleep paralysis, Jermaine managed to find a better job with a local political organization, and worked full time with them for several months. So he was functioning day to day and working through the mental health struggles that were bringing him down, almost to death. It is difficult to find a job even in the best of circumstances, so finding work showcases Jermaine's capacity to brighten his future through bleak ordeals. He also began volunteering for a homeless youth organization, which

demonstrates his desire to still help others even when he did not receive such help. While he did not save much money, this job allowed him to rent a better and cleaner apartment, and have enough money for food. He took up fitness to lose weight, and started dating a number of women. After graduating from a local college program, he began (and is still completing) a master's degree and currently works full-time at another position.

Towards the end of our interview, I asked Jermaine if he ever had ever received a diagnosis or had a good interaction with the mental health system, given that his survival was so independent. He recounted meeting a psychiatrist at a local outreach program sponsored by a church.

Jermaine: They're like, 'we kind of think you might be Bipolar', I guess my story gave off that impression to them. And I don't know maybe I am. I don't know (laughs), I really don't even know, because I know...They said it once and they're like, 'here's, from what I understand Seroquel is something that is being over prescribed right now'. One thing they pick up on when I went to the church with the free lunches and breakfast, and they had...the outreach team from [psychiatric hospital]. So like a woman would come in, and once in a while an actual psychiatrist would show up...And he actually told me, he's like 'the first thing you need to do is get off Seroquel.' And I'm like really? He's like he basically went into this spiel about how it's become this, it was originally kind of like the higher dosages were for schizophrenics, like...something they use in hospitals when they're trying to sedate...But it becomes this thing where they use really low dosages for just getting them to pass out and I'm like really? I'm like if I knew, I could have just gone to the pharmacy and gotten Nyquil or something. You know what I mean like?

Finally, Jermaine met a psychiatrist who told him the facts about over-prescription of heavy sedatives, and admitted that he had most likely been given the medication not to address his symptoms or situation but rather put him to sleep. It is no surprise, then, that Jermaine experienced a great deal of torment, despite taking the medication regularly. Although the psychiatrist did not agree to follow him, this one-time encounter affirmed to Jermaine that the mental health system does make mistakes, and that if he wanted to improve his mental health, he would need to withdraw from the medication and find other resources – doctors

who might give him the time of day for more than one encounter, and perhaps prescribe him a better medication to manage his symptoms. He still is unsure of the label given to him eventually by a doctor at the community health centre, and indeed, given the lack of supports he received in this acute period of illness, it is hard to discern how much pathology interacted with his stress and dire life circumstances. Moreover, he has no reason left to trust doctors who he was willing to listen to and follow their directions from the outset of his mental health problems, even if it was just meant to put a band-aid on his issues. His compliancy with incompetent medical staff, in this passage, has transformed into disbelief and an acknowledgement that the solutions posed to him he could have figured out for himself.

Still, Jermaine did not give up on his adventure to find professional help. He went on to access free counselling services, where he opened up more about his past. His counsellor described him as one of her “favourite clients” because he took a lot of responsibility for his situation.

Jermaine: So I ended up having this pretty cool counsellor, a few. Who turned out I ended up being their favourite client in the whole...And so like I had her for like, we're supposed to only have 16 sessions and we ended up having double. She's like yeah, I guess, she said this was me and I guess maybe this is part of it too is that...basically all the other clients except for maybe one or two. Blame somebody else. So they never get to the heart of why...their life is the way it is. Whereas me, I'm like, 'this is where I messed up.'

Jermaine frames agents of the psy-apparatus as people who appreciate others who take full responsibility for their actions. It is easier for some than others to blame ourselves when things do not work out a certain way. Yet as Lawn et al. (2015) interrogate in their research on community treatment orders, this moral framing seems to be “more about the worker wanting people to appear to be better, to be more socially acceptable, rather than the person actually feeling better about whom they are and what they feel or think; so that the worker

then [feels] better about themselves and their effectiveness as a worker” (p. 13). At the heart of Jermaine’s narrative is an utter lack of help from the outside world, and we learn how someone whose life is relatively stable can take a quick turn when family, peer, and formal support is next to non-existent. Jermaine’s story serves as a reminder to all to question the very privileges and environments that keep some of us from falling over the edge, and shape the duration and extent of the pain. I am privileged, and I fell over, but my family and, eventually, caregivers, picked me back up. I asked him, in the closing minutes of our interview, how he thought he had survived all of this, and he chalked it up to a kind of willpower and the deep desire to write his own story.

Jermaine: I only literally...in the past six to eight months really feel like I’m not...battling this anxiety thing anymore...Even though some of them, like they’d make the argument ‘because you didn’t internalize it that’s why you went through all that shit.’ But, and I thought about this. I think, I don’t know. I think some of it is also you don’t wanna...like part of the reasons I never actually killed myself had to do with...I didn’t want people to say ‘oh...he killed himself because of all of these’, I didn’t want it to be like, ‘oh it makes sense he killed himself he was homeless and because he looked’, you know ‘because he was on’, I don’t know how to really say it. I didn’t want people to, if I was to do that, to then be like ‘well I told you so’ or something, you know what I mean?

The thought of having others explain away his suicide as the expected conclusion to his tragic situation gave Jermaine a great deal of courage. He wanted his story to end a different way, and not be held up as an example of tragedy in the mental health system and class disadvantage. While he is active on social media about mental health initiatives, he feels that the discussions rarely move beyond the Internet, and that in-person openness carries true healing potential and reduces stigma around mental illness. Jermaine’s story reminds us how rare and difficult it is for people to survive homelessness and severe mental distress, and that mental health system failures sometimes come at the cost of someone’s life.

## *Chapter Summary*

Stories about trauma, loss, grief, pain, bewilderment, and mental anguish are difficult to tell (Butler, 2001; Larabee et al., 2003; Spencer, 2012). They are also hard to get right. Doug's narrative, while it may speak to some 20% of what he remembers, provides us with a glimpse of both the good and the bad side of madness. Doug believed to have the bonds of the universe revealed to him, to stare Truth in the face and have his conscious implode into the mysteries of the galaxy – none of us can truly know that traumatic excess the way Doug knows. He speaks to and about the irreducible nature of such experience with the understanding that although he may have lost the grip he had on an alternative reality, he carries with him gifts and outpourings of abilities he otherwise would not have known if he did not fall ill. It is so difficult to describe in words this kind of imaginative and ineffable feeling, but Doug's story, incomplete as it is (Doucet & Mauthner, 2008), paints a picture of hope and resistance to the master narratives of psychiatry. What is left for the reader is a transformation we can label spiritual, since simplistic rationality lacks satisfying explanation. A service user in Farber's (1993) early work referred to a similar feeling.

I felt a connectedness with every other living being, with everything. And I felt at times I had the ability to know what people were feeling. It wasn't merely a thought of my relatedness to other beings, it was an experiential knowledge. In normal consciousness for me there is such a thing as a stranger, there is such a thing as a person that I'm not related to in any way. But in this other consciousness I am very well aware of my relatedness to people just as I normally am with my own brother, my mother or my father. I felt very good...I knew that what was going on was valid for me. (pp. 82-83)

After the interview with Jermaine concluded, he mentioned to me that he had never told his story in this much detail before. He mentions in the narrative how at intervals with caregivers, doctors, and hospital agents that he told them the whole story, but that picture was never complete enough to warrant intervention. All the working parts of Jermaine's

assemblage (racialization, class disadvantage, substance use) interacted to paint the picture of a man who was just down on his luck, and who, at the very most, just needed to get a good night's sleep with the help of a strong sedative. Doug's inability to fully communicate the pits of madness may leave some wondering what exactly it feels like to achieve a Zen or heightened ecstasy in moments of panic and paranoia, while for Jermaine, the ineffability of storytelling resulted in a deepening collapse and may have played some role in not allowing him to get the help he needed. Although the eye of madness found him, others could not or simply would not see it, and thus he relied on his selfhood to survive.

The agency both Doug and Jermaine describe during their mental breakdowns demonstrates that even in the darkest pits of madness, some service users can still maintain enough awareness and hope to carry on with their "mission", and try to survive (Bonnnett et al., 2018). This threshold and spectrum of ability nuances literature and mental health acts that pit those experiencing a psychotic collapse as completely out of control and always/already dangerous to themselves and others (Chandler, 2014; Federman, 2012; McSherry & Weller, 2010; Peay, 2003). But what exactly does it mean to be dangerous or carry a diagnosis of a mental illness, which something even neuroscience is incapable of pinpointing to an exact degree, even though its research is improving (Kirmayer, 2015). And does it need to? While we can understand Doug's agency in the story he tells years after, the here and now of madness, in all its dark glories and intensities, suffocated his ability to communicate in the real world, and this is the face of madness that most caregivers, friends, and family members see. Szasz, too, may very well have been aware of the self-capacity afforded to even the most disturbed, but it was misguided to mobilize those impulses into rationalist and libertarian principles so the law could act more harsher upon those who

commit harms during these periods of crisis. In both Doug and Jermaine's cases, the danger was more to themselves than others, and in actuality, they were even able to help themselves escape from madness. That said, they still faced the terrifying reality that they could have lost their lives or hurt other people, as it is hard to analyze the fluctuating levels of control they had over their actions and bodies, and coherence in general.

This is something they may not know themselves, and so we are left questioning how exactly to determine levels of intervention needed. Thoits's work (2006) suggests that those with better mental health, high levels of coping, and less distress are generally able to express agency better, including problem-solving efforts and purposeful acts. But Doug and Jermaine counter these findings by demonstrating their high levels perception with respect to their madness, and ability to go on surviving psychotic symptoms with, in the case of Jermaine, minimal supports in place or, in Doug's case, experiences with overt control techniques and displays of power.

In Doug's case, he was taken to hospital, but described tensions with the way he was infantilized and forced to eat against his will. He resisted the dominion psychiatry tried to impose on him by challenging the caregivers' perception that his state of mind meant that he had no control, or that he was not peaceable and gentle given his spiritual outpourings (Thoits, 2011). Even during his restraint, he mustered the strength to use passive resistance techniques, placing all the onus of psychiatric violence on the caregivers. Secondly, the people Doug describes in the psychiatric ward deflect the stereotypes that some people experiencing psychiatric disturbances are purely violent and irrational (Thoits & Link, 2016). The picture he paints of an otherwise terrifying woman playing the violin beautifully for the other patients demonstrates that it is possible for some institutionalized service users to

transgress their illness, as well as the mundane and prison-like environment, with artistic passion and courage. Doug found some sense of community in the hospital (Herman & Musolf, 1998; Leyser, 2003; Wood et al., 2013), whether it was during brief exchanges at mealtime, understandings he gained of others as not so very dangerous after all, or the empathy he felt towards homeless people, who like himself, were also trying to recover and piece their lives back together.

Jermaine, on the other hand, lacked community and family support. On his own, he was unable to find any kind of helpful intervention until much later in his narrative when he found a counsellor who would listen to him, albeit because he took the brunt of responsibility for his situation. He also found a psychiatrist who, in one encounter, instructed him to get off the medication he was on that was being detrimental to his health and well-being. Family members and peers can provide critical support to people living with serious mental illnesses, and in some cases their involvement can decrease the likelihood of suicidality, increase chances of receiving adequate mental health services, or partially alleviate some symptoms such as depression (LeCloux et al., 2016, 2017; Pernice-Duca, 2010). In one instance, running into a couple of friends near a department store saved Jermaine from a suicide attempt, and early on in his homelessness, Jermaine received some financial assistance from his elderly uncle. He chalks up a great deal of his survival to chance. It was by chance that he ran into those friends; it was by chance that he endured homelessness during the summer months with very few resources; it was by chance he survived meningitis for so long before receiving treatment; and it was by chance that he finally regained his breath when he experienced sleep paralysis.

Not everyone, of course, could have survived everything that he went through, or expect to have had the agency the three of us did during those dire circumstances. We are left with a need to further interrogate the psychiatric system, not just on the mistakes they make in action (Burstow, 2016), but also the grave errors that are made through a lack of intervention. An absence of intervention nearly killed Jermaine, and this abdication of responsibility on the part of frontline workers occurred several times in his story when he reached out for help. The responsibility of the state to care for him was downloaded into the form of a small pill that did very little to address the pain caused by his deplorable housing conditions and psychotic symptoms, and very much validates studies that document how racial minorities tend to receive less mental health support and treatment than whites and those with upper and middle class incomes (Broman, 2012). We can do better, and we must.

## **CHAPTER 7: “THEY COULDN’T SPANK THE SCHOOL”: NARRATIVES OF INTENSE PARENTAL PRESSURE, SOCIO-ECONOMIC TENSION, MENTAL UNRAVELING, AND INDIVIDUAL RECOVERY**

### *Introduction*

This chapter is about the role family plays in shaping mental health concerns and illness. In all three stories, we hear about the breakdown involved in trying to navigate extreme pressures to achieve in school and rise quickly through the ranks in a capitalist system and hierarchy. Zach, Simon, and Aisha’s parents never really understood what mental illness was. Their struggles were shaped by a pressure placed on them to work hard. As their mental health faded due to a number of circumstances, Zach experienced Bipolar Disorder and depression; Simon developed a serious stress disorder from about the age of 4 and on, while Aisha engaged in self-injurious practices and also experienced psychotic symptoms. We learn in this chapter how complex family, racial, and socio-economic dynamics shape the life course of one’s mental health journey.

Zach describes his family environment as going beyond the everyday pressures a parent might put on their child to achieve and do well in school. When he encountered the psychiatric system, the experience re-located the intense responsibilities and discourses he confronted onto the institution. He discusses his understanding and the significance of his label, Bipolar. The agents he encountered in the system helped him understand that some of his issues were pathological, and not a result of his individual failure. He trusted some of the professionals he met, while others he framed as culturally insensitive to his upbringing and mannerisms. He concludes with the sentiment that the mental health system should be intersectional and sociological in terms of its framework for care, which is to listen to and look after others.

Simon's narrative intersects with Zach's. He describes an intense family environment that pressured him academically. Being an immigrant from Eastern Asia, he had difficulty learning English at such a young age, and although he is fully fluent, he was never able to master it to the extent of achieving "As" in elementary and high school. He developed a stress disorder as a child that gave him nightmares and severe anxiety over anything concerning English. Psy professionals helped him to boost his self-esteem and vent about some of his problems, and he eventually came to forgive his family for the role they played in his mental health.

Aisha's story demonstrates her resiliency through family difficulty and disjuncture, bad feelings during adolescence, and engagement in self-injurious practices. She discovered artistic mediums to help cope with her mental illness, and while it was instilled in her that asking for help meant that she was weak, she overcame those feelings by accepting help from a teacher who reached out to her. She recounts a positive experience with mental health professionals who convinced her that her condition required medication to treat. Still, her pain reached unbearable peaks as she battled suicidal ideation, which through a complex ordeal, she managed to survive. Aisha ends her story with concerns over the stigma of having a mental illness, and the obstacles service users face with respect to interpersonal relationships.

### *Zach's Story*

Zach, another friend of mine, is a younger adult originally from Eastern Asia. In the years that I have come to know him, I have found him to be polite, sensible, sensitive, and deeply empathetic. That being said, it was obvious to me from the time we met that he struggles socially. It is easy for others to overlook how reflective of a person he is, not to

mention that he is also incredibly accommodating of other people's needs. He shares deep concerns for the pain others experience, and takes a lot of precautions when he speaks to ensure he does not trigger or irritate his listeners. Zach begins his story by describing to me how his problems with mental health started and continued throughout his adolescence. Zach's journey would lead him from a place of fearing everything that stood outside his parent's rigid expectations, to gaining strength in a new (psychiatric) identity, to becoming highly critical of the psychiatric system he once idealized.

Zach: I mean obviously looking back with tinted glasses, I felt like I always had mental health...an arbitrary beginning point would be somewhere in high school...long before I received any sort of psychiatric care, I think it was in the beginning of grade 11. When I went to my counsellor in high school and requested psychiatric evaluations. Psychology/psychiatry was all the same to me...I always felt that I could trust them. Maybe it's my scholastic upbringing, or my soviet style when I was very little. I never had any severe fear of...institutions. Especially institutions relating to care...I never felt quite completely plugged in to real social life. And, I felt that people in institutions and authority figures judged me less for not being cool...so I felt safer around doctors, nurses, um, even the rude nurses perhaps. And perhaps even the cops. When I'm in front of authorities, being uncool was not a minus it was a plus. And to them it probably meant I'm less of a troublemaker.

Zach's inability to relate to his peers gave Zach a special status with authority figures – people who Zach felt would not judge him for not being “cool”. His individualization was heavily cultured as he was socialized to accept authority figures and their role in his life (see Kleinman, 2011). Indeed, childhood bullying carries drastic repercussions for adolescent's mental health (Singham et al., 2017), so Zach frames institutional authority figures here not as the cause of his pain, but rather the safety net he could lean on in times of worry, even if they would take some control later on his life over the shaping of his identity.

His parents' authority, on the other hand, was something Zach struggled deeply to accept. Growing up in an abusive home with no escape hurt his relationship with his parents, and he felt that they were a roadblock to obtaining good mental health. Since Zach had little

in terms of peer and parental support to help him through his mental illness, professional guidance was the next best path, so he asked his counsellor at high school for a psychiatric assessment.

Zach: And...the expert they brought in had no legal ability to give me anything more than a cursory assessment. And the cursory assessment was...that the stress I was undergoing was not outside the norm. But they would need parental permission to dig deeper. And there was no way that I could secure parental permission...in my household...this was not something you bring up...because mental health was too important to me, I wasn't gonna risk getting my parents involved in this process...the flurry of 'buck up's and 'man up's and effortizations...and responsabilizations, would be way too much. And the only way I could get them to accept the existence of [my] mental health [issues] was to bring a medical proof from a system infinitely stronger than they were.

There is literature that documents how families resist cultural discourses about mental health (Boschma, 2007). In this case, Zach's family resisted the now more accepted perception in Western society that mental illness is real and ought to be treated by professionals. Mental health, in their purview, was something that could be obtained through individual efforts, rather than institutional help. Zach had tension with this perspective from a very early age, and did not want to risk his parents' involvement in his psychiatric journey because he did not want to be subjected to their discourses of blame and responsabilization. His situation was a bit of a catch-22: to undergo a full psychiatric assessment meant that his parents would have to give permission, but getting permission was impossible to obtain in a family that seemed to value achievement over self-care. Doing so would have resulted in a gendered retaliation against Zach's identity, which was something he was struggling to pin down. Not pursuing this assessment also meant that Zach remained mostly on his own to deal with his issues related to adolescence.

Zach: I had a series of crushes in high school. I didn't know how to talk to them. I wasn't able to discuss that with my parents either because their upbringing was really Puritan. Um...uh dating was, would have been frowned for the same reason

that...getting care was frowned upon. It would be frowned upon for the reason of...being a distraction from my studies. So basically anything having to do with emotional growth was treated as a distraction and a frivolity. I had a saying at one point, that...during my teenage years I had to be my own mother. I had good peers. But...they weren't the kind of peers who could offer advice or support...I wanted a personality, if that made any sense...I felt like I didn't have an identity and I wanted one...I just...wanted to be...in a category. Because I felt that made my identity legible. And my need for...mental health and mental care cannot be separated from that.

Romantic, family, and identity issues shaped Zach's descent into mental breakdown. He told me how the issue of "destiny" always cropped up when mental health came into the picture. He was concerned with trying to figure out who he was, and also what his life path should be. This was not an easy consideration in a strict family who wanted to choose that path for him, namely a university degree that carried an intense pressure to succeed. They often tried to mold him into a hardworking careerist, or to use his own words, a "neoliberal individualist" whose daily activities and routine revolved around obtaining a career in the sciences.

Perhaps this narrative is a retaliation against the "tiger mom", coined by Chua (2011) to describe the disciplinarian and strict form of parenting some East Asian, South Asian, and South Eastern Asian parents engage in to ensure their children attain high levels of academic achievement. Wanting your children to do well in school is not necessarily bad, but Zach's position is that this parenting approach may come at the cost of a child's social development and emotional well-being. At no point can I infer that this environment caused his later mental illness, as there are many who experience mental illness who were not abused as children. Still, this kind of pressure was difficult for Zach to deal with as a child, especially when his family was dysfunctional, struggling, abrasive, and unrealistic about their expectations.

Zach: ...my dad started to get really, really aggressive during those three years of unemployment. But to my mother, obviously my mother worked. She was the

breadwinner for a good few years. Obviously I'm not blaming her for anything but just non-judgmentally speaking, she wasn't the best support for my dad. At the mental level...A lot of my early teens was growing up in that household. Waiting for the next moment when they'd take things out on me. Cuz they'd fight, but then, whoever lost the fight would take it out on me. And if they needed to...have some way of reconciling, joining up against me and reprimanding me was like a regular activity...I was living in a war zone. Just waiting for the blame shells to hit me and cut off my leg...But whenever my parents did the dishes, I remember just trying to wait, wait for the next loud drop of the dishes. And I know that a yellin' was coming...I remember on the night my family...came to [Canadian city]. I got yelled at for the stupidest reason. You're gonna laugh when I tell you. My dad...saw...a grade 6 math champion on the newspaper. On like...the local news. And he was mad that it wasn't me.

Zach also discussed with me how his grandfather suffered paralyzing mental health problems near the end of his life, and when his father encountered despair from the loss of his job, his mother saw Zach's grandfather in him. A deep-seeded vulnerability for mental health concerns afflicted Zach's family, and often these circumstances would converge in the household, which then developed into family disharmony. Indeed, many adults experiencing mental illness never receive the care they need, and the role that family plays in overcoming mental health treatment barriers is poorly understood in the literature (Thériault & Colman, 2017). New findings indicate that when individuals are aware of lifetime treatment history in family or friends, they are more likely to access the psychiatric system themselves (Prokofyeva et al., 2013; Thériault & Colman, 2017), which echoes Zach's experience.

Further, from Zach's point of view, mental vulnerability meant that one was incapable or worse at being productive and supporting the family. Sometimes their socio-economic struggles turned to anger and included one extreme case where Zach was unfairly compared to another child who had a moment of success. It was not about finding out what Zach's gifts were, but rather viewing him in terms of absence in comparison to what others achieved. These struggles were exacerbated by the fact that his family situation included

periods of poverty as well as tensions in racialized neighbourhoods when they first moved to North America.

Zach: When my family first came to North America, we were living in the States, ...[with other] international people...The neighbourhood was good but it had the highest rent in town. So, food was an issue, we couldn't afford furniture. I ate a year's worth of cereal. The halogen lamps were banned in the neighbourhood, cops would often go door to door confiscating halogen lamps [flammable]...I got good at hiding the lamps when the cops came because you got the best lighting out of those lamps...And that would be a way to go door to door and like keep tabs on illegal people. In the ethnic migrant community, there are rumours and I think this is true, that the cops use child abuse...as an excuse to scoop ethnic kids away from their parents. So I mean as a kid, I had a choice really. If I somehow said that I wasn't having the greatest time at home, that my parents were disciplinarian and so on, I would have been scooped and if the authorities for whatever reason didn't scoop me, I would be abused at home for ratting out, or I could stay in silence.

Zach referred to this practice of authorities taking ethnic children and placing them in often white dominated foster homes as “killing the skin and saving the child”. Forced to live in precarious and run-down housing with little food and furniture, life growing up for Zach was not easy. Alongside his problems dealing with the parenting style of his mother and father, Zach still showed a solidarity with them insofar as he participated in tricking the police so that their housing would have more heat. The mention of the term “ratting out” suggests that his family did not view police authorities as incorrupt figures, which is found in other work examining perceptions of police (Wu, 2014). Zach feared the police presence because losing his family was something very frightening, even if they were not treating him always with love and compassion. However, he also feared retaliation by his parents, who were struggling to make ends meet in a racialized community entangled by child welfare concerns – concerns that may not have recognized the cultural differences between parenting in the West and in other parts of the world.

Afflicted by many struggles, it seems that Zach found little refuge in his childhood. Socially, his parents were all he had, but he found it difficult to co-habituate with them. When his family moved to Canada, Zach describes how his parents continued to reinforce a tough morale in him.

Zach: Every time we visited [Canadian city], my parents would take me through [university] campus for strolls. Hoping, I don't know, that the vibes would rub off. But...every time they'd take me for these strolls...I would be...semi-lectured/reprimanded for not working hard enough. Not being born gifted...not being in grade nineteen when I was nine...pressure doesn't begin to describe this, you have to factor in the fact that I had nobody to look up to and didn't know who to be. It wasn't pressure to be something. I was being told to do things that I could not process because I couldn't connect it to a way of being...Like it's the same problem, gifted kids are in the newspaper 'why is that kid not you?' It wasn't designed to respond, right? Like that's what power is. Like I say something to you, that sounds like you could respond. But you really can't. That way when you can't respond you feel more like an insect. Right, you feel more dehumanized. What better way to dehumanize a child.

Zach identifies the kind of power-over relationship he experienced as a child as a language game. Being asked questions under the pretension that they could be answered, but actually could not, displaced Zach into a subordinate and unresponsive status where he was forced to accept his parent's disappointment and ridicule. He describes this kind of family environment as going beyond the everyday pressures a parent might put on their child to achieve and do well in school. Instead, he was abased on a daily basis for not accomplishing things that some people take a lifetime to achieve, such as attending university, winning math competitions, and so on. While he never accepted his parent's strong "encouragement", confronting it directly risked severe punishment and abuse. Dehumanization, in this sense, means having no escape or very little capacity for resistance, much like an "insect", to use Zach's words.

Despite his perception that he would never be able to achieve what his parents wanted for his future, the day came when Zach got accepted into a program at a Canadian university.

Relying heavily on his parent's financial support to sustain him throughout this period, he became very distressed and depressed in the first weeks of the program.

Zach: I had huge issues with my roommate, who was also depressed, who also didn't want to do [university program]. And we fought. And [my parents]...said that if you switch out, we're not paying your tuition...I was groomed to be a [university program] person. And the way you groom someone to be [in this program] is to make them not know anything else. I was failing midterms. I tried to go to the psychiatric system on campus. Starting from the third, fourth week. But I had no idea how to deal with the real system. This was the system I was barred from...I thought I was allowed to get help behind my parent's back. I didn't know how to do it...I went for like one session and never went back...I felt like I was being questioned in a way that didn't get at where my problems were. I mean later on I found they flagged my mental condition in their records, right after the first meeting. But I didn't know that. I mean, unless I know from my therapist that you're not gonna responsabilize me and effortize everything in my life and give me the same 'buck-up, man-up' type of thing, I can't trust you. I could not face the prospect of having a psychiatrist tell me that I was healthy. That would be unbearable because that would mean that I have nowhere else to go to for answers...it would imply that I'm on my own...That everything would be my fault...again.

Zach points to a fixed ontology; he knew that the type of thinking and way of being required of him was not for him, but at the same time, his grooming to embody the demeanours of his university program left him with no alternative. The better life Zach wanted was far beyond his grip because engaging it meant trying to think and feel a different way. Much like the prisoner in Plato's cave, he knew this imaginary life was a possibility, but he was afraid to confront it, and had no knowledge of how to do it. The education system that his parents propelled him into was his life, and very quickly it was becoming unliveable. If he tried to escape it, his parents threatened to remove their financial support, and Zach felt that he had no other resources to try something different. Usually, parent-child health and well-being is linked with parental financial status and social support (McConnell et al., 2011). The fear of imminent financial hardship if Zach resigned from his program would have placed even more stress on his family relationship. The issue of socio-economic destiny likewise cropped up

again; if he did not finish school, he was not going to get a good job, but to do so meant becoming obedient to his parent's wishes.

Looking for answers, Zach accessed the formal psychiatric system for the first time, behind his parent's back. Their initial screening attempts made him feel that they were not interested in what was really causing him to suffer, namely family and identity concerns, and a fear of poverty if he was cut off from financial support. He was also deeply frightened of the prospect of being told by a care professional – someone whom he generally looked up to with respect and admiration – that his problems were, as his parents put it, a result of a poor work ethic and lack of ability to achieve beyond what the average person can. He did not want the psychiatrist's office to turn into an echo chamber because that experience would ruin him emotionally, so he continued on in his studies without any professional support.

And things did not get better.

Zach: I failed every course the first semester of third year. It was just not sustainable. Um...it created the crisis needed for me to get full psychiatric care. Because...well...you can't reverse your grades by working hard so my parents lost that card. And because the system came down hard on me, ironically it gave me the power needed to, to confront my parents because no matter how much they beat me. They can't beat the school. The school did to them what they did to me. They...did not accept but they have no choice. And that was wonderful. It was great. At the school clinic for mental health...They gave me an Asian psychiatrist. [Doctor] was really good. Like she understood where I was coming from. Um, we had several sort of preliminary diagnostics. Um, again, I wasn't sure if they were gonna find anything wrong. What if they say the same thing everybody else says. 'It's your fault'...but that wasn't what happened.

Zach used the fact that he was failing out of all his classes as a card to convince his parents that he needed more than just encouragement and lessons in self-help. Since he was not achieving, his parents became desperate enough to give Zach their "blessing" to explore a professionalized form of treatment. This is an interesting mix of agency and a lack of agency. Zach believed the medical system was "infinitely more powerful" than his parents were, and

so he saw the establishment as a place of retreat – something to conform to in order to receive care. But that choice to accept the system and resist his parent’s authority and perspectives on his problems was his to make. Now that he did not have to deal with the fear that his parents would write off his concerns for his mental health as an escapist strategy, he started developing more self-awareness during his diagnostic sessions, and became more comfortable as he learned about his illness, which involved bouts with depression and identity issues.

Zach: So I just sat through the first couple of sessions really just answering whatever, giving her my biography as best as I could remember. I appreciated being able to give her a map of my mind...I think it was into our third session, I felt like the questions were going nowhere. She was just eliciting questions, taking down everything I say. I didn’t know where they would lead. And...when she asked ‘do you have suicidal thoughts’ I started laughing uncontrollably...according to her a huge smile crept onto my face and she says ‘why are you smiling’ and then I started to laugh. And then I couldn’t stop laughing...for the rest of like the session. So she says ‘ok, what’s on your mind right now?’ So I said, ‘my biggest worry is that the system would tell me I’m healthy. Because then I would have no answers...of why, I would have no answers to anything, what am I going through, what’s going on, what’s the problem. If you told me I’m healthy, I wouldn’t know what to do’. Because if I’m healthy...then I had to work. I had to apply effort. But my effort was used up...She says ‘I think that’s the least of your worries’...I was so relieved. When I got the label [Bipolar]...I had something to wear. Something legible...it was like one of the greatest things that had ever happened to me.

Just as Doug described in Chapter 6, a label of Bipolar disorder for Zach turned into an embracement of the psychiatric institution as a site of care. Hearing for the first time that some of his issues could be chalked up to mental disorder came as a relief because it shouldered some of the responsibility and burden of his life onto pathology. It removed the intense responsibilities and discourses of blame his parents put onto him, and replaced them with a sense of needing to be cared for. Zach now was also a victim and wounded child rather than a recalcitrant failure. The medical system, more powerful than his parents, provided Zach with a new word to carry around with him that could fight off attacks and

ridicule, and he narrates this event as a great day of victory. He was tired of trying to work himself out of his rut, and needed to access different methods to cope with his situation.

That is not to say that this new road he travelled was easy. Handed a prescription for a heavy anti-psychotic, the side effects hit Zach hard. However, he found ways to use the drug to his advantage.

Zach: Was prescribed risperidone. The weight gain, the breast development, all of that, I didn't mind any of that, I mean [I] hated the weight gain more than the breast development...there was a period of my life after where I exercised fairly faithfully but...there was no way to hold it off. I kept gaining weight for a couple of years. I mean you sleep ten hours a day. Thought less about stuff...as promised by the doctor, it helped with memory...I could memorize stuff. I mean I was getting 30s and then I got 80s...The less critical thinking I had, the better I did. The less I questioned the curriculum, the better I seemed to do...it was at that point I lost faith in [the university program] completely. It didn't reward critical thinking...it rewarded obedience and that's what the pill gave me...it allowed me to emulate the caffeine high required to pull all nighters. Or at least it be awake. So when I get off the drug, it's as if a normal person drank coffee...

He may have been losing confidence in his body, but the pill enhanced Zach's ability to recall difficult material for exams, and it gave him the obedience he needed to build social capital and conformity to the curriculum standards and expectations. Some education literature involving kindergarten children describes how teachers may prioritize implementing obedience into children rather than a moral value system (Kawashima & Martins, 2015). The comparison here is rich: while the pill made Zach question the curriculum less, his newfound obedience sparked a revelation that the university program was molding and infantilizing him into a person he did not want to be. Even though his grades improved, his faith in the program was completely lost because he realized that high grades equalled conformity, which would not ignite his thinking into new, untested forms of contemplation. Just as his parents had silenced Zach's capacity for resistance through abuse and language games, the pill took away his will to resist.

Even though he had to conform to his parents and psychiatrist's expectations, Zach also points to an agency, as he used the pill's withdrawal effects to his advantage. In my own experience, risperidone withdrawal creates (at least temporarily) high energy levels and mental highs during the first day or two. During periods of intense boredom during my recovery, I used these highs to write academic papers better and more efficiently, as I found that the break from the numbing effects of the medication gave me a sense of euphoria. Zach recounts his own experience in greater detail.

Zach: So I'd take the pill...and so three days before the exam, I'd study a lot with the drug. Two days before the exam, I study a ton pulling all nighters without the drug. Until I have to sleep or until I get some sleep. The third day, so the day right before the exam...no drug, I study like a normal person would, and I sleep normal, like as if I was normal. Then I wake up, write the exam with other crip people in the special detention centre...report myself in, go through the check point, be shown to my cubicle, I would write the whole thing...And that would be it. If I need to sleep, I sleep. If I usually don't sleep, I go back on the pill...It wasn't that rational of a process. I mean...when you're in that kind of warzone for so many years, you tend to develop a sixth sense of what works for your body. A lot of times the sixth sense would be right, other times it would be wrong. But there was no time to stop and reflect...[my parents] had to accept it. They couldn't spank the school.

Zach's use of the medication goes beyond the standard instructions most mental health users receive when they are prescribed any type of drug. Rather than take the medication consistently and at the same time of day, Zach played around with its withdrawal effects to give him an advantage while studying – something other students, unlike himself, could do by drinking a lot of caffeine. Although he was complimentary in the interview about the niceness of the invigilators at the “special detention centre”, he subtly points to a stigma of having to go through a separate process to meet his special needs as a newly diagnosed student. Zach had a keen sense of how his body reacted to the medication, and he could even regulate his sleep schedule. The end result was that his grades skyrocketed. This process, too,

was not “rational” but intuitive, pointing to a conceptualization of agency that is less knowable but more experiential.

Moreover, rather than frame himself as not living up to the schools’ standards, he sees the school as taking on responsibilities that his parents used to manage for him. There is a transference of power and authority – a process which Zach accepts to some degree given his newfound success. He did not need to retreat from the university program, but he learned through the psychiatric and school system how to manage its expectations better. People with serious mental illnesses are more prone to other cognitive impairments (Rönngren et al., 2014), but Zach overcame these through his agency to take control of his medication, and allow the school and psychiatric power to take control over some aspects of his life, instead of trying to live up to his parents expectations.

Achieving higher grades in the university program, however, did not give Zach the identity he craved, nor make him feel any better about his future destiny. What that identity is we did not discuss in great depth, but coming to know him personally, I could tell that his journey in the academy was not separate from his life identity search. Eventually, he made the decision after graduating to complete a Masters degree in a different field. While his undergraduate program required “obedience” and strict, routinized studying schedules to be successful, the shock of engaging in scholastic critical thinking took its toll on him very early on in the program.

Zach: I quit [the medication] when I entered grad school. That’s when I got suicidal...withdrawal itself was not the worst, it was the culture shock of the [program]. It was extreme...my first experience in a seminar room...I didn’t know what to do or say. I never had to participate in a classroom. Um, all I could tell was that I didn’t fit in. I literally went to my intro to curriculum professor, and asked them ‘...am I thinking the right way? What are the thoughts that I’m supposed to have in this course? Tell me what thoughts to think and I will think them. I want to succeed.’ And...I encountered a lot of racism in that classroom. From an older white woman.

There were several of those incidents in particular that made me really really fearful. I learned a couple of things the hard way. I mean...it turned out that [program] culture was the same, just as mindless as [the other program] culture...the fascism is a little less, the hypocrisy a little more. I treated school as the opposite of a courtroom. You don't have the right to remain silent. Every misinterpretation of what you say can be held against you...every cultural fumble I did...was interpreted by the older white woman in the room as 'oh masculinity'. I support the feminist and progressive sentiments behind these discussions. That's not where it hurt me...I was just learning...how to behave in a safe space.

Zach was challenged to critically think about issues he never had to think about in his community or education in a more hostile, emotionally charged classroom setting. This was shocking to him, and his opinions were scrutinized despite him trying his best to get a grip on a healthier discourse that was inclusive and spoke to the interests of the marginalized. He was desperate to the point of looking for someone to tell him bluntly how to think. He frames other's reluctance to be patient with him as a misapplication of feminist theory and politics, because, in his eyes, his perspectives and ways of communicating about these topics were likely shaped by his cultural identity and upbringing rather than always/already a result of him being a man.

Guckenheimer and Schmidt (2013) explore the divides that arose in a classroom setting between beginning sociology majors, who were just becoming exposed to topics of sexual violence, and more experienced feminist activists who were very knowledgeable about such issues. Students on both sides of the spectrum felt that they were being silenced by one another. Zach's experience seems to echo these sharp divides, however rather than try to escape education altogether he went so far as to ask an authority figure how he should think so that he does well. He had difficulty reconciling his desire to think critically on his own terms with his aspiration to communicate respectfully and safely with others. Now that

school power was starting to bring him turmoil, his choice again was to try and conform to the discourses and rituals of learning rather than challenge him.

Indeed, there is no easy way for outsiders to talk about gendered violence, but as a person who grew up rarely being able to fit in, the hostile classroom environment pushed Zach into experiences of suicidal ideation. He knew he did not belong in his undergraduate university program, but now he was labeled an outsider in another program, a program he told me later he entered because he wanted to “teach teachers how to teach”. Feeling very low, Zach reached out again to his psychiatrist, but this time it was not a positive experience.

Zach: [Doctor] left...because I was struggling with racism now and it just so happened that my new psychiatrist is an old white lady...It wasn't just triggering, she was mean. She was dismissive...She's your typical you know British grandma that used the word 'manners' to be racist to you...like it was the first time in my life history when the psychiatrist system wasn't on my side...I just never went back after two meetings...And the medicine stopped as well...Also cuz I turned 25 and I was no longer covered by my parent's prescription, that was also a factor.

Rather than elicit responses to many questions and build trust with him over a long stretch of time, Zach's new psychiatrist was more forceful and assertive, and viewed his newfound issues of trying to cope in the classroom as a problem with his manners. Once again, Zach took this as an offence against his culture, where the ways of speaking and being do not always conform to the expectations of white settlers. Institutional racism has been known to plague the structure, procedures, and culture of psychiatry (Timimi, 2005). More specifically, Keating et al. (2002) found that stereotypical views of minorities, racism, cultural ignorance, and stigma associated with madness often undermine the ways in which mental health services assess and respond to the needs of racialized communities. Racist conceptions lead to the idea that racialized groups are less deserving of treatment that would lead them to recovery (Patel, 2014).

Zach's narrative aligns with some research that shows that more punitive and restrictive forms of treatment are meted out to these groups, especially when they are confronted by a white psychiatrist (Bhui & O'Hara, 2014). He felt looked after by his previous doctor, whom he felt shared some of his racial and cultural background, but now, Zach felt betrayed for the first time by the medical system. Because he stopped seeing his psychiatrist, his medication prescriptions came to a halt, which for a student with no major insurance plan or good source of income was difficult to afford on a tight budget.

Stricken and becoming more suicidal by the end of the term, Zach checked himself into the psychiatric hospital on Christmas Eve to get help, only this time his feelings of assurance in the psychiatric system were strained.

Zach: I mean...spending a night in [psychiatric hospital] on Christmas Eve was you know, on the same order of magnitude as getting a botched up surgery for hernia...The crisis response...was...very good. But...by that point I was guarded. I was no longer telling everything to the therapist...I mean the suspicion is obviously gonna be permanent. But uh...I think the biggest issue, that I can see is that...in the field of psych support, social awareness is optional. That's the problem I think...Because...I mean I'm gonna be blunt here, this is just my opinion. Social work is not compulsory in psychiatry. And intersectionality is not compulsory in social work. That's the double problem. So racist grandma was two steps removed.

At another point during our conversation, Zach recalled a near-death experience where he awoke during his hernia operation [which he alludes to in the quote above], paralyzed and helpless. While this experience was quite painful and most likely frightening, he stated that "dying was great because it wasn't school". To some degree, experiencing suicidal ideation took Zach away from some of his other problems, and he was able to receive adequate care in the hospital before being discharged the following day. It is echoed in the mental health literature how hospitalization can help some patients turn off their life problems for a little while, and focus on their self-care before confronting another major life obstacle (Katsakou

et al., 2012). What he wanted was for someone to listen to him and become aware of the problems he faced that made it hard for him to communicate in the everyday world. If you know Zach, it is not difficult to see that he struggles to make meaningful friendships, and he is very guarded about what he shares with people until he builds a great level of trust. This is partially because does not want to hurt others with his words, or encounter social backlash. When he built that trust with psychiatric professionals – amidst structural problems that often make doctor-patient interactions very short, controlling, or dismissive – Zach framed his experience as helpful. His initial experience with psychiatry was idyllically parental, whereas when the system became overly parentalist and lacked empathy for the problems that were causing him to access the mental health system, Zach felt racialized and discarded. Care, to him, needed to be present, intersectional, and prioritize listening over advice-giving.

Zach: I am going to go out on a limb and say that these people need care...And it's not even a question of giving them advice. Because the first thing I think about when you give them advice is...you're making care conditional...Care turns that on its head...the lens of care...comes from a position of listening rather than telling. It accepts the possibility that you can't understand that other person. But you're willing to listen. Because while silence may not be absolutely universal, it is relatively more universal than speech...and, if people came to me for advice, I would just start by listening. And...and not judge...everybody has pain. And the way to be democratic about pain...is to ask ourselves 'is my pain getting in the way of having others fix their own pain?' I mean...heck, even showing solidarity may be painful if you had a really prejudiced upbringing, but at some point you have to ask, shouldn't there be limits placed on my comfort, so that others can get what they need? The point of me saying this of course is that, you know, at some point, um it's not just about my pain...the beef we all have with psych is that it's not social.

Zach closes our interview by offering a reminder and a caution about the complexities of care. Is psychiatry capable of care, or should that onus be placed in the hands of other caregivers involved in the mental health system? In psychiatric meetings, he was looking for care from the person responsible for diagnosing and prescribing him medication, and sometimes he received it, and sometimes he did not. Initially, what his psychiatrist would tell

Zach gave him feelings of comfort and resolution, while at other times he did not accept what was being told to him, especially when it came across as overly assertive, confrontational, and culturally prejudiced. Perhaps there is a balance to be struck in patient-doctor relations and degrees of caution to be taken when asserting authority in what is very clearly a power-over relationship. While Zach framed his mental illness as being the result of challenges to his identity and destiny, we also see in his narratives that it would slip when he did not receive adequate care from his family members, colleagues, teachers, and mental health professionals. His call for a more humanist approach to psychiatric treatment is resonant with approaches towards sociological inquiry, where listening to other's stories and trying to make sense of them after building a long-standing relationship is an epistemological priority.

### *Simon's Story*

Simon is a friendly, polite, and enthusiastic young man with a solid sense of humour. He emigrated from Eastern Asia to Canada a few years after his birth. Growing up poor in a chaotic home where both parents worked, alongside the discomfort of not knowing either official language of Canada, made life difficult for Simon, especially in school.

Simon: I grew up with Asian parents...there was no English in the house. Very little of it...My dad spoke some English but my mom not a whole lot. And uh...I grew up with my grandfather and he um...[did not speak English]...My parents worked but my mom got home like seven or eight at night and my dad worked nights so I wouldn't see him at night and I'd wake up and go to school...they had just emigrated which is why you know they didn't have a whole lot of money and time to spare. So I didn't see them very often...So I grew up with my grandfather and because of that, I spoke no English and going to school, it was rough. Because...in this place where I have no clue what anyone is basically saying and it freaked me out a lot as a kid...assignments that involved English I got really stressed...I got really...disorganized and tensed up, I couldn't write things, at all, so it took me...a long time to just do anything that wasn't math basically.

Simon had enough basic English to communicate orally at a level that was acceptable for kindergarten, but for tasks that were evaluated and required a great deal of concentration,

such as spelling, he struggled greatly. In addition to having difficulty with the English language, Simon had developed a speech impediment that prevented him from pronouncing certain words. His parents, under a great deal of pressure to make ends meet and do their best for their child, did not understand how difficult it was for Simon to adjust to a new culture at such a young age.

Simon: Oh yeah...I, the whole stereotype Asian parents growing up...why didn't you get an A+; the 95 – 'what happened to the other 5%' kind of thing...there was a lot of pressure and, I didn't do too super well about that pressure...things were very tense with my dad and I, we argued a lot and we fought a lot... He was hard, yeah...I will be perfectly honest, I really didn't even speak to him until basically when I went to high school...I...I...don't like to say it but as a kid I kind of hated my dad... I didn't like him because he just...he put so much pressure and was super strict about everything that it just...I didn't, I couldn't stand it. Right and especially going through like the angsty teenager phase, it just didn't help that he was super restrictive about everything.

Amidst discourses emphasizing the freedom of migrants to build their own identities in an academic environment (Kindt, 2018), there is a growing body of research that indicates that pressure to do well in school and the academy is extremely high for some child newcomers (Portes & Rumbaut, 2001; Shah et al., 2012; Zhou, 2013). Experiencing this pressure so young, Simon started to develop mental health issues (see Grice & Hudziak, 2016). His stress levels were increasing, and he was not responding well to parental pressure. He was trying to do his best to learn English at a level exceeding that of many children whose first language is English, but the most he could accomplish throughout grade school and high school was average grades. This disappointment led to tense feelings against his father. However, his parents, mostly concerned about his grades, did get Simon an individual education plan to see if his needs could be met.

Simon: They'd...I'd guess concerned enough that they had requested the school, is there anything we can do like? So...I got an IP [individual education plan] for the stress and the stuttering and everything because I needed extra time to do tasks and

stuff especially when I didn't know something. I didn't adapt very well I guess and...I got really tense and things got really disorganized. And words [would] just be everywhere, you would just see random things, like scrawled on the paper and everything...so I needed the extra time to actually...think about [it].

Zach, whose parents felt that he could accomplish more by “bucking up”, were different than Simon's who addressed early on that their child might have special needs. What they did not realize was that their constant bickering over his progress was intensifying his problems – issues that for some may not appear to be issues at all, such as needing to be an A+ student in grade school and speak a new language to perfection. He describes his relationships with his counsellor and speech impediment therapist as generally positive, as he felt less pressure in these environments and was given some concrete strategies to do better in school.

Simon: The school had, I saw two people. One for my speech impediment the other...I think I had stress problems but not in the sense enough for like, to take medications or anything...So I saw a counsellor to help me with my stress and disorganization, because I was really disorganized. I still am. That didn't change whatsoever...I did start in grade school, so past kindergarten. Which is when...my desk was a total mess...It was just papers, jammed...it carried into my work basically...I just had numbers and letters written everywhere because if I couldn't spell something I wrote it down until, until it looked right...It was like a school counsellor, one of the special ed teachers, because... especially with tests I just got really stressed and I just couldn't write. Like I would blank...They just helped me get through that stuff...how to study and how to just like you know, relax you know during a test.

Simon preferred math over English because math did not “lie” or have “hidden meanings”, whereas the rules of language tend to fluctuate, and he could not handle that kind of chaos. It might seem overkill for such a young child to receive so much help just to improve his grades, but the support people reduced some of the pain he experienced writing tests by teaching him relaxation methods, and encouraging him in a healthy manner.

Simon: With the stress of like you know doing like, say, an English test was just not helping, and I just, and at some point you know, I did lock up but at others I just didn't care enough, I was like this was hopeless, I can't do this, this is not going to go anywhere I could sit here for literally an hour and just at this one question and not

know what to do with it...Um...they, they did encourage me to keep trying. But not in the like the sense of my parents who were like, 'why aren't you getting [English]' - the negative aspect of it. They kind of pushed me, the counsellors kind of like helped me get through with it, whereas my parents made it seem like just this big wall of like 'why aren't you doing this, why can't you get past it?'

The counsellors played a different role in Simon's life than his parents did, as they encouraged him even in the midst of continuous struggle and failure. His parents, on the other hand, were not patient and demanded that he simply overcome this obstacle he faced in school. To them, his inability to ace English overrode the fact that he was utterly gifted at mathematics, a more universal language. Rather than nurture those gifts, their focus remained on what he was *not* good at, and this struggle evolved into a stress disorder and feelings of hopelessness. With the help of his therapists, Simon eventually overcame his speech impediment, and at about grade 6, stopped feeling as stressed out. When I asked him if he felt his disorder was as a result of pathology or his circumstances as a child, he described it as being a result of both.

Simon: If you put like any kid in like a really stressful environment they're going to grow up with these stress related problems, right? You can only stress and condition kids so much to be resistant to it before they (snaps fingers) snap right? So...I think it is to a certain degree, definitely like a situational thing where your environment, who you grow up with, what your life is like, definitely has an impact but at the same time, I, I know that there's obviously like a chemical...you know, difference in it...it can be treated with you know say antidepressants or whatever or you know, anti anxiety drugs, the plethora of them. Um...so, do I think that it's an illness at the same time? I think to a certain degree it is, if an illness can be treated...with actual medicine. I'm in [the sciences], I could definitely tell you anxiety related issues are definitely a thing, that you can definitely treat with different types of drugs right, so I think it's definitely a bit of both. I think maybe some people are preconditioned to it, maybe there's some you know genetic uh...component to it that makes them more...predisposed to...being easily stressed. Um...that's definitely a possibility.

Mental illness, in Simon's eyes, results from a mixture of chemical and environmental imbalances and circumstances. He does not deny the need for some people to receive treatment from drugs, as some scholars are heavily skeptical of (Moncrieff, 2008), even

though he was able to live with his stress without that form of treatment. His studies in the sciences confirmed to him that the brain is responsible for the experience of symptoms, and also can be treated chemically to improve people's lives. That being said, Simon is adamant that anybody could experience the pain he did if exposed to a detrimental and high-pressure environment that pushes children past their limits. The consequences can also be permanent.

Simon: I don't think it was coming back but I don't think it ever left...mental illness will never really...as you go through life I think, it suppresses, I think it goes deep down but I don't think it ever goes away. Because...um...you know you can, if you take drugs for instance, all it really does is suppresses us as far as it can go and you just hope it never comes back, and if it never comes back you could say that it never, it went away. Right? If it never comes back, but I think for a lot of people it comes back every once in a while, it haunts them...I still have dreams about you know sitting at my desk, having an English test and then not knowing what the words are, they look like English but they're not English in my mind, right? I still have dreams like that every once in a blue moon.

His words send me a chill as I recall the many night terrors I had of being psychotic long after my acute recovery. These dreams came to me again a couple of weeks before my second psychotic break in the winter of 2018, and despite having a long period of remission, they reminded me that there are no guarantees that some serious afflictions will never return. Simon too is haunted by his condition over a decade later. But he uses his memories and reliving of trauma to create a scientific knowledge of his illness, demonstrating his agency to really take a grip on understanding his disorder. His stress seems to be shaped by an interaction of family dynamics, child maltreatment, and rigid school expectations. Despite this understanding, he still points to the unpredictability of mental illness, and limits of our knowledge over the complexity of its existence and return (Yang & Tsai, 2013).

While the condition itself may never go away, there is hope that Simon has moved past the pain his parents caused him.

Simon: Once I started high school... I didn't...have that, I guess hate for my dad anymore. He just mellowed out. I kind of thought to myself...it [would] be wrong for me to say he's done any specific wrong to me, he's never you know...did anything abusive on me. So I don't have very good reason to stay mad at him, but that doesn't mean I have to like him. I can love him as a child loves his dad, right? I have talked to my dad like, we, I don't want to say made up because there was nothing, there was no anger between the two of us, just kind of, you know, definitely not a friendship by any means either. Love or anything remotely related to that, right? So I told him you know I don't think you were an amazing dad by any means, right? He accepted it right, and he knows, he's working a hard job and you know, I was just trying my best and everything and you know, he knew he was hard on me he just wanted me to do well, like it was for my benefit more than his...listen, I accept that because you know, I can see where he's coming from, he just wanted...the best for his kids kind of thing...Even if, his methods leaves something to be desired...I don't walk by him and instantly hate him by any means. It was you know uh...it's just he's my dad and that's all it is.

Simon found peace with his dad, even if it is a love-hate relationship where he blames him for much of the stress he had as a child. He developed empathy for his father's situation, working a full time job and trying to support his family after having just emigrated to Canada with very little money and time to spare. His father also was in a car accident that left him home-ridden for some time, depressed, and taking anti-depressants which affected his mood a great deal. Partial amends has helped him come to terms with his illness, whereas Zach still faces difficulties confronting his parents or being truthful about his feelings for them.

When I asked Simon if he had anything to say to people who might be going through the same struggles, he parted with the knowledge that doing one's best is all that we can do.

Simon: I got a lot more...I guess relaxed when I started going through high school, I started to realize you know....if you just try hard enough at something, it will be fine...But if you try your best and the problem is still there, that means I can confidently say to myself I did everything in my own power to fix this problem and there's nothing more I can do, like nothing within my own power to fix it right and because of that I would just, I don't want to say, I took a more relaxed attitude on things but I just accept that if I try to do something and if it didn't work then...it didn't work, right? That's not like uh a puzzle, there is a solution right? It's just life...Do I wish it never happened? Yeah, I do. I wish it never happened. I don't think any kid should really go through that kind, like mental pressure by any means. Stress isn't a bad thing, I think it's a good thing to be stressed, I think it is a good thing to

lose, I think losing is a part of, a natural part of life and I hate to say it, I embrace it a bit too late into my life and...my parents didn't help with that because you know 'you each gotta be the best, you gotta be really good at everything' and I realize you know, and you can only...if you don't do something it's not the end of the world...best to just live life one day at a time.

Similar to how Doug recommended a "do a little better each day" mantra, Simon insists that simply trying one's hardest will lead to positive results, and if those results end in failure, then one should still encounter no regrets. Stress is a natural part of life that can be beneficial, but Simon is clear that no child should have to go through what he did, that is to say the point where stress becomes too overwhelming and contributes to a pathological disorder. More than the help he received from counsellors or peers, Simon's recovery here is marked simply with a change of attitude. Although he perhaps did not agonize in the same acute ways that other participants did, he demonstrated an agency to take his condition into his own hands and develop a life philosophy and maturity that worked for him and eased his symptoms.

### *Aisha's Story*

Originally from Southern Asia, Aisha is an undergraduate student living in Canada. After many years of reconciling her faith, she prefers the faith of Islam, and has studied very deeply many of the world's religions such as Judaism, Christianity, and Hinduism. Her story is a very touching and sensitive one that involved many battles with self-injury, suicidality, despair, and self-identity issues. Like Zach and Simon, issues with her parents were always front and center with her mental health concerns.

Aisha: So my family is from [Southern Asia], and both of my parents were professionals, and um...in spite of this we don't really have the best mental health framework. While I did not grow up in [Southern Asia], I grew up in the Middle East before moving here...and when I was young, especially in seventh and eighth grade when this was just starting to hit me...I didn't know how to cope with it...I can trace it to as early as maybe...fifth or sixth grade...prior to that I remember certain things

like I was always a very...quote unquote 'sensitive kid'. Um, in the sense that when I was young, as young as I would say five years old...I was the type of kid who if someone looked at me and smiled I assumed they wouldn't take me seriously. Or I would interpret as ok, am I being laughed at? So that kind of caused me to be very very shy just kind of in my shell for a really long time. That took forever for me to come out of...was feeling really terrible all the time...I didn't know how to deal with what I was feeling. And so there was a lot of um...self-harm. Just a lot of a self-destructive behaviour.

Aisha's sensitivities around other children caused her to feel inadequate and deeply insecure about how she presented to others. These issues struck her at a young age, and she carried them throughout high school. Eventually her bafflement, anger, and insecurity with how others communicated with her turned to despair, and to cope, Aisha turned to self-injurious practices. Her other outlets to express her deep and troubling emotions, such as journal writing, were not enough to combat the pain she was feeling.

Aisha: I think that lasted...four-five years, towards the end it was a little bit more like, and initially it was anger. You know, just anger at myself. Not at others, and it would always just manifest as me you know trying to cope with it in a way that involved causing harm to myself. And um, I didn't really have any other outlets, I used to write a lot, I used to read a lot, just try to distract myself quite a bit, um...but I was still functioning, my grades were ok, they were good, I was always a straight A student. Up until I wasn't (laughs). So because I had promised myself I was like 'you know, Aisha, if things ever get too bad then you will tell your family and you will go to a doctor and...' later on that's what I ended up doing, but at the time, still in high school...I was just like you know, there's no reason for me to feel this way...there's tons of guilt cuz...that's a culture thing...people be like 'oh you have everything you need, you have a roof over your head, you have food to eat, you have a family that loves me', yeah...it was terrible, like my stomach was discoloured for I think five or six years, like only recently has it returned back to its normal skin tone after all these years.

What Aisha felt inside needed to be expressed outwardly, and self-injury manifested as a routine practice to regain that sense of control, something that she eventually feared would cause permanent damage to her body. While the pressure Simon felt resulted in a severe stress disorder, Aisha experienced a number of mental health breakdowns and illnesses, all of which her friends and family thought were the result of a lack of gratitude for

having her basic needs met. One study found that the relationship between mental health and immigration relies on several contextual factors such as their family and neighbourhood situation, social position, support and exclusion, and exposure to discrimination stress (Alegria et al., 2017). Before Aisha emigrated to Canada she had a lot going for in terms of socio-economic status and family support, however some of the emotions she was dealing with as an adolescent were not manifesting in a healthy way. She recalls what it was like when her parents discovered some of her injuries and scars.

Aisha: Yeah, and their reaction was always every single time...anger. You know, 'why are you doing this, we've given you everything'...every time and towards the last couple of times I was just like 'guys you know if this is still happening then maybe you should try to understand why it's happening instead of guiltting me into feeling bad about this cuz I'm just gonna'...and I, I found more creative ways to do it without people finding out. So like I, from my arms, to like the back of my calves and then I switched from my calves to like my stomach...and then, the anger just kind of...turned into a sadness...that was constant in these couple of years was just this feeling of emptiness and just feeling hollow...I started to develop more textbook symptoms of clinical depression where I started to lose things that I used to really enjoy...I was just watching these things like slip away from me in front of my eyes and I was like oh my God, no, none of my coping mechanisms are left, I don't like anything.

With her emotional and mental stress going over capacity with the new feelings of guilt her parents were trying to place on her, Aisha's despair turned pathological and added yet another card to deal with on top of everything else she was going through. Her identification of "clinical depression" suggests that these symptoms were arising biologically, and something that she could not really control. Her parents thought she might be able to regain that control; hence Aisha was at odds with their lack of attempt to "understand" what exactly was going on. Her path continued on a downhill trajectory as her grades started to slip, and she lost even the activities and passions that had previously kept her strong throughout

turmoil and distracted her from the many worries of life. The parental response to her academic 'decline', as was the case for Zach and Simon, was harsh and discouraging.

Aisha: So all my grades were Bs, and my parents just lost it completely and they were like, 'no, that was like you know, blah blah blah dishonored, dishonoured', I use that word half jokingly but that is literally what they said um, in my language. And you know, my mother... 'your dad can't you know when his friends ask how you did in the exams, he won't be able to tell them with a straight face that you got Bs'. Cuz it's a big deal in my culture where I'm from...so especially since I was...very high achieving to them I was just wasting my time...my family was very strict with me especially. During high school, so ninth grade to twelfth grade, I was not allowed to bring books homes...I did not really have a cell phone until I was 18...So I had nothing, I had no recreational activity at all. I wasn't allowed on the Internet...I wasn't allowed on my Xbox, so that was four years...And it showed up in tenth grade with some of my mock exams, just weren't up to par. My parents walked in, they sat down, 'ok, is something the problem, what's wrong, let's try to fix it, why are your grades dropping', and I straight up told them, 'well I have to go to med school after this? And that's not something I want to be studying for.'

In Aisha's culture, bringing dishonour to the family carries serious ramifications, and in this case, her lower grades were taken as a sign that she did not care about her education in the least. Even though she had achieved straight As up to this point, the constant focus on the negative created an family environment of dysfunction and toxicity. People with new immigrant status face other barriers to achieving good mental health, such as problems obtaining quality jobs in safe work environments, encountering fewer opportunities to enhance wealth, and finding appropriate networks that are emotionally supportive (Takeuchi et al., 2007). For someone just about to move out of the country, perhaps her parents knew of the difficulties Aisha would face in another region of the world, which is difficult to process for anyone, let alone someone engaging in self-injury.

But school was all she was allowed to have, so by not living up to her parent's expectations, there was little Aisha could retreat to in order to restore a sense of balance in her life. Not only was she expected to achieve top-notch grades, but it was under the

expectation that she would use those successes to get accepted into medical school, which in the Middle East is ultra-competitive and a difficult endeavour to finish. With no one to turn to, and little else in her life to maintain any sustainable level of distraction, Aisha tried to replace one form of self-destructive behaviour with another, and then tried to escape it entirely through more healthy means.

Aisha: I had a desk in my room that I'd sit on to work, I would scroll hateful things all over the desk about myself in permanent marker, just writing things about how I'm worthless, useless piece of skin, no redeeming qualities, just all over my table so every time I sit on the table I'd see those and I'd add more everyday...I was mostly alone. Through high school time...you know I went from having thoughts of always wanting to die...thoughts of 'I hope I get hit by a bus when I'm crossing the road'. And dead serious. But, also around that time, was also when I tried to reduce the self-harm, so cut down on it because it was kind of getting quite out of hand, I was worried that I was going to do some permanent damage...I had like a journal. So I would channel, I would write a lot, I would write my feelings down in a story, or presented as an abstract piece of writing and that really helped um at the time just because I had so many thoughts and so many emotions...And it's funny as I got better I found myself transitioning from less abstract pieces to more stuff like fiction or things that I actually enjoy writing that are not just a reflection of, you know my thoughts and things in my head.

Art can be a helpful endeavour for mental health service users to undertake to improve personal and public understandings of mental health, enact a safe space to create, build better identities, as well as help heal and vent the personal and social costs of mental illness (Bone, 2018; Ryan et al., 2015). Aisha told me fictional stories and abstract pieces of writing appealed to her initially because she could hide the fact that the problems the characters experienced in the stories were the ones she was really experiencing. Writing served as a medium to share just enough of the truth of her pain, and in a way that maintained some level of restraint and privacy. She traveled through a process of having no escape to some escape, all the while trying to reduce her self-injury and preserve her body. The characters in her story, while giving her some comfort, did not replace the fact that she had few friends to

open up to and who did not judge her. Then one day, Aisha met a teacher who provided her with the caring and non-judgmental qualities she needed in an authority figure.

Aisha: I had a teacher in eighth grade...we used to talk. She was my English teacher, and of course she um...noticed certain messages in my writing. And I think she had this system where she asked us to keep a journal, and you know she would check our journal every week. And the journal could consist of anything, you could write poems, you could write essays, just anything to get you writing...Um, I think I kind of used that tool to my advantage. There was a bit of a cry for help in there. And she noticed it...she was like you know 'I want to talk to you during recess' and I was like ok great. And I talked to her and...she really helped me out a lot. And initially I was a little apprehensive because there was this whole, you know cuz no one had really tried to help me out with this before. And I was just like in my head, 'I don't need help this is fine, everything is fine'. But over time, I did grow very close with her and, she'll hold a special place in my heart, we still talk, and she helped me through a lot of things.

Unlike some of her peers, this teacher did not second-guess Aisha, and tell her that she was engaging in self-injurious practices to gain attention. Her writing triggered a first-response to her mental health crisis, and the teacher—someone who held authority—became a support figure. Because her family told Aisha that she essentially had no problem and her problems would go away if she worked harder, she was still resistant to help at this point. Focusing on the symptoms of her affliction rather than the causes and stresses precipitating them made her feel as though she still had some element of control over a very serious issue that was spiralling out of control, and revealing new afflictions and behaviours. Much of this chapter has critiqued the limits of psychiatric and parental authority (see Jones, 1999), however by letting go of some of her own inner control and accepting the need to get help, Aisha developed a relationship of care. Her agency in this case is demonstrated by her ability to reach out to someone outside of her family and peer network by putting messages into her writing, and in turn accept their help when they reached out to her. Unfortunately, the teacher's help could stop her symptoms from verging on the spectrum of psychosis.

Aisha: I was not sleeping at all...and then I resorted to pills to knock myself out, not very often, but I think there was a point where women...you don't really need a prescription for medication there...In terms of symptoms, when I started losing sleep, especially around the time when I was super suicidal and I was like you know between medications and trying to figure things out. I started seeing things. And it was just horrible, like auditory hallucinations as well...Yeah right as soon as I was about to fall asleep or right after I wake up, my psychologist called them visual disturbances and I don't remember the official name for it, like the medical formal name for it. But that was scary...I literally feel like there's little creatures hanging off my insides and just like eating away...I also started having wacky dream experiences, just the more stressed out I was, I would be dreaming with my eyes open, so like imagine yourself asleep but your eyes are open and you don't know you're asleep. But you know the dream is taking place in the real world, so you'll have the real world setting and then you'll be hallucinating alongside. It was very scary.

In addition to trying to cope with her pain through over-the-counter sedatives, Aisha turned to heavy metal music because she described its sound, or "noise", as matching her "internal wavelength". Spence and Gwinner (2014) document how art provides options and concessions to authorize mental health service users' dialogue, agency, identity construction, and eschew the dichotomies between mental illness and art. In that vein, the notes of rough and edgy guitar allowed her to connect with her hallucinations, and this produced a feeling of calm at times. Other music, that she did not choose to listen to, on the other hand, gave her migraine headaches and even caused her to vomit on the rare occasion. Although her mind and body were seriously deteriorating, Aisha was finding ways to stay alive and mediate her symptoms through whatever means she had available to her in a strict, surveilling household. Like Jermaine, the lack of sleep caused to experience sleep paralysis and have encounters with the surreal, especially during her dreams.

Despite these growing states of delusion, intensifying pressures, and bodily shutdown, Aisha got accepted into medical school.

Aisha: And med school, I got in, I did somehow...And I was just done. I was just like...I can't deal with this...Um, and then I had an episode...so we have mock exams, and in order to sit through final board examinations you have to pass your

mocks. Um now...a month before the mock exams, I just stopped functioning...I didn't want to do anything, I didn't want to read, I didn't want to write...I was supposed to be studying but I couldn't study, I'd look at the words...and trying multiple times a day, I'd open my book and I couldn't, like the words were literally, they were swimming, I couldn't read...everything was hazy and it was really bizarre, and it scared the life out of me and I was like oh my gosh what's happening? How [could] I fix this?...and that's when I think more of the fatigue started to set in...one of my least favourite physical symptoms was just, I felt really heavy all the time. So not exhausted, not tired, but like my fingers for example, it felt like someone had injected lead into my arms so my arms were like five kilograms or ten kilograms heavier, or someone attached a weight to my fingers. It was...you know a chore just to life my arms up.

Mental health resiliency can be defined as a defence mechanism that enables people to thrive in the face of severe adversity (Davydov et al., 2010). This is why resiliency has been promoted among resettled refugees and migrants who may not have access or know how to navigate the mental health system in their new location (Andermann & Simich, 2014). In the face of going through all of this, Aisha managed to pass her mock exams. Madness did not defeat her, but meanwhile at home, her parents just could not understand why she wanted a way out of medical school. Still, her mother identified that Aisha needed professional help, and insisted that she see a doctor.

Aisha: My mom and I...we're the exact same people which is problematic because we were both butting horns constantly. And we would fight on a daily basis. Every single day literally, I think...it was horrible, it was very toxic, and you know she would tell me, the counsellor, 'you need to get away from that environment, you need to go to a university that separates you from your family for a little while, just so you can sort it out...' [My mother] still took me to the family doctor and I talked to my doctor about it, and my doctor suggested counselling, therapy. Um, she tried to hook me up with a psychiatrist and she also referred me to a psychologist...and she wanted me to start medication...I on the other hand, was like, 'mmm no, you know what let me just wait a bit...' because to me, I felt like I was...weak. You know? For wanting to take medication or for needing medication. And you know she would try to tell me...it's necessary...I was constantly just asking her for validation. Like I'm not making this up, right, this is not in my head, this is actually a problem that I have. And you know my doctor would tell me yes this is a problem that you do have and probably should get on medication for it. Um...so I would see her regularly on a weekly basis...And it was nice, it was helpful. But it didn't really do much for me in terms of the whole cognitive aspect and the fatigue. Just the lack of energy.

After many years of struggle, Aisha entered the mental health system and describes her experience as helpful and positive. Initially, she held reservations about taking medication because the lessons instilled in her about being tough and managing pain on her own made her feel like taking medication was a weakness. To accept help is not to be resilient, as the terms in her family's eyes seemed to be mutually exclusive. In Aisha's case, she was incredibly stressed from family pressure to engage in a career she did not want, and she had very little healthy coping mechanisms. But we can applaud Aisha's survival on her own, and lament that taking medication could be framed as a lesser kind of evil to managing illness. This is at the centre of the stigma of mental illness (Fox et al., 2018): having a mind that is damaged and in need of treatment – treatment that may only actually suppress symptoms and never cure the disease, as Simon discovered.

Aisha's doctor worked hard to dispel feelings she had that she was not ill, and emphasized that she had a problem that needed to be fixed and managed. This was the first step Aisha needed to begin a long journey of healing. Her doctor was the antidote to some of the concerns she was experiencing with her parents, who despite their medical background, had little understanding about mental health concerns and their legitimacy. This lack of understanding turned out to be dangerous, as Aisha survived by the skin of her teeth, negotiating self-injury and suicidal tendencies. While this intervention was a step in the right direction, Aisha recognizes that it did not cure everything. She worked on her deeper issues with her psychologist, but the self-injury and suicidal tendencies continued.

Aisha: But my psychologist was not like that at all he was very um...curious is the word. He genuinely wanted to know what I felt and why I felt what I felt. He just found it all very interesting...But my family didn't know this...I was still self harming...and I really, I would be doing all those crazy things which I probably should have been locked up in a hospital for...my google search history was why

should I not kill myself? You know, and then I would ask my friend, my best friend... 'please give me reasons why I shouldn't do this'. And you know I was just like 'kay, your points are valid but I don't care'. And then it was at that point that I was like... even while I was doing the attempts in [Southern Asia], I, this was after I had met my doctor and she wanted to get me on medication, but I didn't get on it... I remember what I thought right before I took the pills, I was like, you know what... try and talk myself out of it, as soon as this is over you can go back to Canada and you can get on medication, and you can see a psychiatrist. It will be fine, you know you don't have to do this. And then my next thought was... I don't want to. Like I don't want to spend the rest you know, ten years of my life like this, I don't want to get better I just want it to end.

Aisha discloses to me in more detail the events leading up to her suicide attempt:

Aisha: So I was on this medication and I was doing a lot of self-harm... And then I was like... on this one specific day... I did some really bizarre self harm things that day. Just things involving really hot liquids... And on that day, the day that I decided this, my mother... somehow stumbled across some of my self harm. And got really really upset. Now... of course she did. But the problem was that... since this was my second medication I had some left over pills from my old one, and I've been holding onto them because I'd look at them occasionally... my google search history at this time, it was no longer why should I stay alive. It was ok... what drugs should I mix?... And she said all these things, 'I thought that the psychologist was helping you', and cuz... we didn't have insurance at the time so it was expensive... Blah blah blah, yada ya. While she was talking I just kind of made a decision... this is it. I don't want her to suffer like this anymore, I don't want my family to suffer. And um... my siblings could tell that I was really, really messed up... and finally, while my mother was saying all these things the doorbell rang. This was all just set up in a very weird way... she went downstairs and... as soon as she went downstairs I went to my bed, I took my Zoloft and then I took... like two bottles of those... like sixteen. And I took like, some left over pills, like thirty of those. And what I needed to close the deal, was blood thinners. So like a ton of aspirin. I hate taking pills. So I didn't take them. So here I am... it's funny because my mom came up and she was... visibly calmed down and you know, she was crying and she hugged me and she was like you know, 'you don't have to do medicine'... and then I agreed I was like yeah, I don't want to do this... I was very sick for a couple of days. I also didn't sleep for three days as a result of the medication. It wasn't the kind that would put you to sleep forever, it was the kind that would cause you to... bleed internally until you just passed out.

The darkness in all of our lives can reach points where they become devastating and unlivable. Aisha finally had enough of seeing the pain her family was in because of her suffering, and to invoke a cliché, she was just sick and tired of being sick and tired. Had she taken the aspirin, odds are she would not be here to share her story, so some force held her

back just enough. And following this suicide attempt, we come across a narrative of reconciliation. After their blow-up, her mother gives in to Aisha's concerns about doing a career she never wanted to follow, and they hug, make amends, and share a moment of connection and understanding.

Life was not always great growing up in my household, either. In Simon and Aisha's narrative, we see glimpse of redemption and forgiveness towards their families. Hamber's (2009) work with people who experienced political violence also demonstrates the role professionals can take in helping them move beyond their toxic past without forgetting it or covering it up. These passages remind me how much I owe my wife, mother, father, and brother for carrying me through my deepest low in life. I no longer carry any resentment, and this shows that madness has the power to destroy and heal, bury and save, break apart and renew. After surviving her suicide attempt, Aisha ended up telling her doctor about what happened, and they made a plan together to help prevent it from occurring again, giving her information for crisis lines to call in the event she felt that low, as well as counselling groups to attend. She got on another medication that she said worked better for her, and as things got better, she started to wean off of it based on her father's advice. Aisha's story closes with a reminder that she will always be dealing with the stigma associated with her affliction, and has to continually find appropriate coping mechanisms to keep balanced and healthy.

Aisha: I keep having to change my coping mechanisms you know cuz something is working today doesn't mean it will work tomorrow. And then I also feel the depression differently, like there's this other one I only felt a couple of times in my life which I'm hoping I never feel again, where I just feel very cold on the inside so, last time it happened it was first year at [university] and I remember I was just chugging you know lattes and hot chocolate and I had like a giant Coke and, I was wearing four layers and this was like in the fall it wasn't that cold but I had like a giant winter coat and it didn't do anything to help because the cold was inside, it wasn't outside my body, and that was horrible, I'm never going through that again...But I think in second year I might have pushed myself, plus on top of,

tempting to wean off, and still feeling bad about you know this disability, I hadn't even registered with the [disability services], there's just a lot of internal guilt and like lots of, lots of shame. It's really not right. It's just not fair, you know? Um, especially because, I've lost friends because of this. Um, people who were like 'you know what you're just too depressing' so even if I don't talk to them about it, they're just like 'no your body language is just too depressing, or you know we don't want to deal with this', [but] I'm dealing with it, you don't have to, you can just walk out the room. You know I'm very careful now.

Like Doug, Aisha lost friends because of her illness and struggles with mental health. She describes her physical pain as something that begins from the inside, and the external components of it materialize into a stigma that she must carry around with her. It might go without saying that it is really difficult sharing these stories with fellow service users, let alone people who do not want to give the time of day to listen to tales that are not easy to hear. Sharing these narratives, however, is a break from this stigma. I felt that both Aisha and I felt a kind of relief in being open with one another, as I told her I also had recovered from psychosis and severe mental distress. While I had no part in their acute recovery from mental illness, my part in these narratives is a listener. In disclosure, there is a triumph over the stigmas of the everyday; the burdens that do not go away; the people who cannot understand why we are a certain way.

### *Chapter Summary*

Recovery, more than sustained remission, is a non-linear, complex process. It is driven by an ongoing struggle to live a manageable and happy life in spite of debilitating conditions that come with many physical and social costs (Davidson & Roe, 2007). Each participant in this chapter recovered at different speeds, lengths, and degrees, and it is safe to say that their recovery, because it is so deeply rooted in childhood struggles and unbearable pressure, will be continuous. Leamy et al. (2011) identify that the recovery process from severe mental illness is often marked by a deep journey of personal change and growth,

where people try to attain hope for the future, redefine a positive identity in the face of mental affliction and stigma, connect with others, and find meaning in life (see also Georgaca & Zissi, 2018; Topor et al., 2006), and some of these findings are relevant across cultures (Slade et al., 2012). This chapter found similarities in narratives of despair from three participants whose cultural settings were quite different before migrating to Canada, but notably were all children of Asian and immigrant backgrounds.

All three participants recognized the profoundly negative effects that dysfunctional relationships with families, peers, and professionals have on their distress and self-care. On the contrary, when relationships became strong and therapeutic and they found people they could trust in their support and care environments, their afflictions improved, or at the very least, they regained a sense of hope that one day they could recover and move forward (Amering & Schmolke, 2009; Anderson et al., 2015; Georgaca & Zissi, 2018). To varying degrees, Zach, Simon, and Aisha developed a critical stance towards the mental health system and the role of family, and Zach and Simon especially had strong senses of agency with respect to their distress and recovery (Georgaca & Zissi, 2017). Aisha, on the other hand, demonstrated more resiliency through her ability to resist adverse symptoms and mental illness, and still accomplish a great deal in the midst of her pain. These findings transgress notions that service users, in general, are passive consumers of psychiatry, have little awareness over its treatments, effects, and consequences, and play little part in their recovery (Campbell, 2013; Kirmayer, 2000). While each participant encountered some economic hardship, they managed to find access to some mental health services, which indeed shaped how they framed their personal recoveries (Harper & Speed, 2012). Jermaine, on the other hand, was refused these services, so these participants had enough class status to

be able to navigate the mental health system. Though their families still were a barrier to them obtaining mental health, they had some protections in place in terms of basic necessities that meant they could focus some of their attention on recovery and treatment.

In Zach's case, he was searching for an identity through the mental health system. His Bipolar label allowed him to recognize that the problems he faced in high school and in undergraduate studies were not all a product of his poor work ethic and a lack of resiliency. The mental health system became a card to play against the power and authority of his parents, and he used his psychiatric sessions to further explore the self, and develop coping mechanisms that helped him do better in school. Rather than label Zach's mother and father as bad parents, these findings demonstrate how little mental health can be understood in families. His entire journey was not positive from this point forward, though, as he encountered racism from another psychiatrist who pinned his issues in the classroom on a difference of cultural standards – behaviors and norms Zach just did not have the social capital to live up to coming from a rigid and strict home environment and difficult education. He emphasized the need for psychiatry to have an intersectional treatment and counselling framework to acknowledge the cultural differences of some patients. Some of these debates have also been taken up in the recent development of the DSM-V (Wakefield, 2016).

Zach identified issues with “destiny” as marking his struggle to obtain meaning in his life. Having his destiny predetermined for him by his parents helped shape the development of serious mental afflictions and personal crises. Zach chose to access the mental health system early in his adolescence to help resolve some of his identity issues, and he framed caregivers as a better kind of authority because, for the most part, they did mirror the judgmental attitudes he was used to confronting at home. In this sense, the mental health

system was a path of escape for Zach, and one that he relied on in the absence of a healthy social life. His relationship with it was still tenuous, as he never completely did as he was instructed to do. The Self was instrumental in how he navigated what he liked and disliked in the system (Loukidou et al., 2013). Zach was building his identity *through* his realization of mental illness and the family and institutional responses to it. He took some level of control over what he decided was working and what was not. By playing with the dosages and withdrawal effects of risperidone, Zach created a study system using the high effect from drug withdrawal that led to better grades. He trusted one of his psychiatrists to get him the help he needed, but this was alongside the idea that he knew his body better than they did, and how to affect it through treatment. And the more he achieved, the more he learnt that his university program was not the career path he wanted because of its pedagogical leanings towards obedience, and this carved a pathway towards more resistant and critical forms of thinking.

Simon, coming also from an immigrant family, experienced similar intense pressures at home not long after he became sentient to ace all of his courses and learn English to better standards than most children for whom English is their mother tongue. The end result for Simon was that he grew to hate his father, and developed a serious stress disorder – one that still haunts him in his sleep. While he was never quite able to attain grades in English that impressed his parents, Simon used the available counselling and support services to his advantage to deal with the acute symptoms of stress, and to a great extent they were effective and made him feel better about his situation. We also encountered a narrative of reconciliation and forgiveness in Simon's recovery journey, as he was able to make partial amends with his father who he blamed, in many ways, for causing his affliction. Simon's

insights, inspired by his studies in the sciences, acknowledge that mental illness is pathological and biologically determined, but he also recognizes that the cause of it is structural and that anybody under certain circumstances will lose their sanity if placed under intensive pressure. Pathology, in his eyes, is permanent and never truly “goes away”, and thus the recovery process is infinite. Simon recognized some of the positive benefits of being under some stress, but felt that what he experienced was far beyond the healthy and even sometimes beneficial levels of stress that can be motivating and stimulating, and into an entirely different category that was intolerable, and not something he would wish on anyone else.

Aisha’s story was a dramatic struggle for survival, and the wounds it left on her body were an outward expression of the pain and anger inside. Her struggles predated formal education and developed in her adolescence, and as she began to try to accomplish great heights in the education system, the pressures exacerbated her long battle with self-injury, and what eventually led to multiple suicide attempts. While both Zach and Simon harbored a great deal of resentment towards their families for similar abuse, Aisha used self-injury as an outlet to relieve her pain and to try and deal with her family’s pressures and influences (Edmonson et al., 2016). She blamed herself for the pain that her self-injury and mental distress caused her parents and siblings, and because she had very little in terms of a peer support group due to strict conditions of isolation, Aisha struggled to access safer coping mechanisms to get the pain out of her system, such as writing and music. She survived suicide attempts, battles with medication, self-injury, and severe mental anguish until finally coming to a place where life became more bearable. She narrated her experiences with many doctors, psychologists, counsellors, and psychiatrists as generally positive, and learned

through their care to accept that she had a mental illness and that her pain was not a product of being ungrateful for her living situation. Still, she struggles with the everyday stigma of not being able to share her story with others, for fear that they will label her as too depressing and unworthy of their friendship.

We learn from these stories that mental illness, stigma, and recovery is a permanent process, but one that is often navigated through extraordinary measures of agency and self-determination (Cohen, 2008, 2015; Kirmayer, 2015), alongside the help of a few caring professionals and peers. Even during isolation, there was hope for Zach, Simon and Aisha for a better future and a capacity to survive, and these inspiring stories of healing in the face of lifelong mental struggles demonstrate that the cluster of forces working to battle against mental illness can save and change lives for the better.

## **CHAPTER 8: NARRATIVES OF EMPTINESS AND ASSISTANCE: EXPERIENCES WITH BULLYING, DEPRESSION, ANXIETY, AND EATING DISORDER**

### *Introduction*

This chapter is about how mental health service users negotiate their own views on recovery, treatment, and psychiatric knowledge with the purviews belonging to professionals. Each storyteller was tasked with a hard life growing up because of an inadequate social life or bullying by their peers. As first presented, Edgar's experiences with domestic violence set the stage for a life that would involve imaginative strategies of escapism; techniques that are very controversial and left me wondering if he was mentally well. His story is about the power of imagination, which he used to create fictitious characters to help him in his journey when no one else was there to help. He escaped his conflict by creating a world that accepted him and did not judge him. He tried to access counselling services, but like Jermaine, was turned away, because he could not pay the extra fees and his insurance only covered one session. Edgar demonstrates the power of resiliency in service users to live on in spite of not having the support needed.

Daniel, who was also a victim of childhood bullying and depression, took matters into his own hands by creating a community initiative, #TheoryOfLove, which seeks and publicizes on social media the mental health stories of marginalized populations and others who are struggling. It also tries to create an open network for people to talk openly about their mental health struggles. Clara's narrative on the other hand is full of support from other people around her. We learn about someone who walked a line between having symptoms of mental illness but never achieving a full diagnosis, something she admitted to wanting in order to put a definition to her pain. She experienced anxiety, depression and elements of post-traumatic stress disorder, but was able to walk through these problems with a

psychologist whom she trusted and got support from. It was a challenge finding the right counsellor, but once she did, the support helped her conquer her problems. She recognizes that the mental health system coddles some individuals, and that based on her work experience with mental health service users, she is worried about people becoming defined by their mental health issue rather than being defined by how they manage or overcome it.

Heather, who like Simon has a background in the sciences, finds that mental health labelling is still an under-researched phenomenon, as she believes her Anxiety and Depression are misunderstood by her doctors. She complains that they treat her Depression with medication but ignore the components of her anxiety because they do not see that condition as serious as the symptoms of Depression. In her case, she engaged a delicate balance between criticizing her doctor's treatment and the power dynamics between them, but also deferring to their expertise. She admitted that she is unsure if the medication was working for her or not. Her story provides some profound service user-centered insights into the experience of a common mental illness, and proposes that the disease should not be studied as mutually exclusive. Her narrative demonstrates the potential of treating service users as shared experts on their own afflictions.

Finally, Hannah, who experienced depression and an Eating Disorder, discusses how instrumental her hospitalization experience was in her treatment, and how her networks of peers and family supported her throughout her recovery. She relapsed however into another bout of depression, and had a long battle with medications. With her parents' support (and not her doctor's), she eventually decided to withdraw from the medication, and noticed immediately some positive withdrawal effects, such as memory recollection. Her story is about the agency of service users to take their mental health into their own hands, and

navigate some of the trivial and ‘lesser evil’ aspects of treatment that sometimes deny service users autonomy and the social necessities required to live a full and healthy life.

### *Edgar’s Story*

Originally born in West Africa, Edgar is an international undergraduate student. He is gifted in the arts and is very much aware of the importance of storytelling and the impact it can have on someone’s life. He witnessed a great deal of domestic violence in his childhood, and had two different high school experiences, one in West Africa and one in Canada. Both his school and home life greatly influenced his mental health, relationships, friendships, and perceptions of people in general. His story begins by describing episodes of domestic violence and ridicule in the school playground.

Edgar: Well I’d say that it started when I was around six or seven. My parents fought a lot...I have a lot of memories of violence... This one time, it got so bad my mom got a knife...and my dad got a table, and uh...he tried to use it as a shield to block my mom from attacking him with that. And I tried to stop them...I’d always cry a lot when they did that. Also, when I went to school, primary school, and high school, I didn’t really have a lot of friends and I was lonely. I wasn’t really getting good grades and I was criticized for that by my teachers, by my peers. And, I just got...sad and angry a lot...I spent a lot of time alone...no one would look at me. I was a skinny kid and people made fun of me because of that. They called me a skeleton, a robot, gay. I tried making a few friends and they weren’t really good friends...And they treated me bad...But still I had a lot of compassion for them. And...um anytime they said something offensive to me, I’d always go back to them. And they took advantage of that. And they used that to control me for my behaviour. And then I ended up hating them for that.

Family dysfunction and adverse childhood experiences can lead to cases of severe depression later in life (Clark et al., 2016), and put children at risk for disrupted brain development and future health problems (Woods-Jaeger et al., 2018). Bullying and hostility struck Edgar at all angles of his life. Growing up in a violent and dysfunctional household made Edgar fear for the safety of his many siblings, and he also told me that he feared that his parents would separate and leave the children to fend for themselves. As the eldest child, he tried to mediate

between his parents, and reconcile their broken relationship. This passage demonstrates Edgar's narrativizable agency to understand and recognize what were abusive aspects of his life, but also the ways in which he tried to navigate the problems without resorting to the same tactics of power he encountered.

After he had taken all that he could stand, Edgar pleaded with his mother to go to a different high school, and he found an opportunity to go to a Canadian high school for international students. While he looked at the move as a chance to make new friends from different backgrounds and cultures, it was not what he expected.

Edgar: And when I came to high school here I thought that I'd have the opportunity of making some friends but my high school was divided. Ethnically divided. Because the Chinese students prefer to mix with their own. The Russians preferred to mix with their own. The Brazilians, the Asians, they all preferred to mix with their own. It made making friends with people from other countries difficult...And uh there were a lot of [West Africans] there, seeing as how I'm from [West Africa], I just didn't want to mix with them because...I just didn't feel like I belonged to that group. But...when I got there, they put me in a [West African] section of the residence building. And I was judged by my own people...So one day I'm playing basketball and a city bus usually passes through the area to get to the residence building. And a couple of guys from my residence building see me playing ball with these kids. And they asked me, later on, why I was playing basketball with a couple of kids that I don't know...and I told them that I asked if I could play basketball with them and not too long after that, they start calling me a pedophile...they started whispering every time they saw me. And started saying that I hate hanging around Black people. Because those kids I was playing basketball with were white...I was just...dumbfounded.

Edgar left his country of origin in hopes that he would leave some of his problems behind, but in fact his situation worsened when he was forced to socialize with people from there – people who outright rejected him during his childhood. Much of the bullying seemed to target aspects of his sexuality, morality, or body appearance, and thus Edgar was puzzled as to why adolescents could treat him the way they did. Affleck et al. (2018) found that Sri Lankan refugees in Canada experienced stress when they could not fulfill typical masculine social roles such as being an independent provider, or were unable to adequately protect

loved ones from physical pain or death. In Edgar's case, he had to deal with the fear that his home situation was remaining toxic for his siblings in West Africa, and simultaneously deal with his peers subordinating his gender through ridicule and moral denunciation.

Edgar describes in more depth how his parents' grave marital conflict continued in his absence, and he worried about the function and safety of the home.

Edgar: When I was there [in Canada] I was always worried about my parents fighting each other because I wasn't there anymore to try to intervene. I mean they fought a few times...and before I came to Canada my parents were just fighting and fighting more and more. Because they would only do it a few times in a year but in 2015 it was...a lot more...And I just decided to...kind of...put on a show. Like I acted as if their fighting was physically affecting my health. I had this broken vase in my room so I poured the shards all over the floor and I...acted as if, I fainted or I had a seizure...our maid found me on the ground, checked my pulse, called my parents...and uh they stopped fighting. They were panicking...And my father was holding me tight, and they took me to the hospital and I faked some symptoms as if it was physically affecting me. And um...I did that a few times just to get them to stop fighting. So fast forward to when I got to Canada, so my parents called me and I always ask them if things were ok in the house. And uh...my father was always asking if I was happy. I wasn't really happy, I was just worried about them fighting all the time.

Throughout our conversation, Edgar seemed to always bring his story back to memories of his parents fighting, and I could tell the trauma he experienced influenced the coping mechanisms he would eventually mobilize out of desperation. His parents were able to afford to send him to a private school in another country and hire a maid, but this class status did not improve the function of his household. A few times, he developed a way to distract his parents from fighting by focusing their attention on caring for him. Edgar saw little chance of ending or reducing his family's constant violence, and used his imagination to create a ploy to interrupt the fighting. Engaging in artistic endeavours has been known to improve the well-being of those who experience chronic mental illness (Williams et al., 2019). Edgar's wide imagination would be the key for his survival in a world that did not welcome him, nor

give him much of a social life. Edgar confessed to me how his thoughts operate on a day-to-day level.

Edgar: So I just...filled my thoughts with stories, my own stories. And I should mention this. For most of my life I've always been in my world. Like, people talk about sports or activities that they do but me...most of what I know are my own stories I created to just escape reality. As a coping mechanism I created imaginary people that treated me well. Imaginary scenarios. And...that's how I coped...up until high school and...parts of university. Still do it...they [imaginary people] didn't judge me like the others did. They treated me ok but...by then it was hard for me to talk to them, form relationships with them because I wasn't really that used to them. Having relationships with people. I expected criticism, sometimes. And I spent time around them. And it was just hard. I mostly do it in my mind and I have a really vivid imagination. I can see my imagination...just like, I'm seeing this whole room right now. And even though it gives me a headache and makes me tired...I'm used to it...I'm so used to telling people about it now, I've told people about it...in different stages of my life. I told my mother about it once and she didn't really react well to it. She actually said I was crazy. Then she apologized later on because she saw it hurt me.

Even the people Edgar created in his own mind to cope with the absence or unfriendliness of real people still gave him some uncertainty. Unused as he was to being treated well by others, he was suspicious that even the imaginary people would attack him, as others had, and tell him that he was not valuable or worthy. But as he developed relationships with these characters, he felt less judged and more confident in his ability to imagine an alternative (and better) reality than the one that never gave him a chance.

Indeed, there is a tendency in western culture to pathologize as mentally ill what seems to be normal experiences for others, and not be open to genuine alternatives to treating life problems others identify (Harrist & Richardson, 2014). Edgar's way of life must have been difficult to admit to when one's knee-jerk reaction might be to call that individual crazy and unwell. Even I wondered about Edgar's current state of mental well-being the more I talked to him, and I suggested to him that he could access the university's counselling services if that was something he felt he was able to do. Edgar assured me, however, that he

viewed this fascinating way of life as something that, albeit out of his control, is not as frightening as other surreal experiences that can manifest. It does, however, come with some physical costs.

Edgar: I get a lot of migraines from that. But yeah I still do it... Sometimes I find it difficult to focus on things. Like when I'm reading, my mind just goes into my imagination... I get the headaches when I try to make it as realistic as possible. I'll give you an example. So I can easily... create people in my mind. But... when I try to make them do certain things like let's say they're fighting or running or... when you're doing certain complex things that humans do, I find it difficult to continue imagining that because it's so... mentally exhausting. And... I try to stop imagining it. But... I can't shut it off. I can minimize it as I'm talking to you now. I still see images. I can minimize it but I can't shut it off... I don't really have control. It's not frightening, it's just life for me.

While Edgar's gift began as a voluntary enactment of imagination for the purposes of coping, it has since occupied his mind to the extent that he no longer sees the mental creations as voluntary. Though he can trigger the beginnings of his imaginative world, once they start doing things that become more and more real, they loosen the reins and run free. For someone not used to such a reality, this might seem frightening and pathological. Yet to Edgar, the creation of fictitious characters (who eventually become real), while exhausting, is just part of life, and they became necessary to live a manageable life.

Edgar has managed to put some of the creative imaginative abilities that allowed him to escape the harsh realities of his life to practical use, as he has developed and written several screenplays, children's cartoons, and works of fiction that he hopes to publish one day. He has crossed the lines between living imagination and written production. I asked him if he would be willing to share a story or two with me, to give me an idea of what these stories might sound and feel like.

Edgar: There's one story I follow, like in high school. It's about an alien race that looked a lot like humans. And they have this telekinetic power, and... so there's a war on their planet. And refugees. From that war came to earth but this was early on in the

20<sup>th</sup> century. And they um basically lived among us in secret. But...their children, at first they don't have this power until they reach puberty. And then when you reach puberty they start to...have these powers...like a few have it and are born with it. And um they're government agencies that are tested with finding and capturing them with this power. And so far they've only been able to capture a few. And when they're close to capturing someone, the person has this kind of...energy discharge that fires electricity and just shuts everything down. And the person of course is knocked unconscious. And in that moment...a ship, that's from their home planet will track that down and pick them up...And then the second story, kind of stories I create are...I'll call them utopian stories. I...know every story needs conflict but...everything is nice and peaceful, everything is working well, there's order, progress. And...it was a story about a country in Africa...in fact more advanced than other countries in the world. And as it's the most secure country in the world. And it has no crime, nothing. And its people are, the society is stable. So it's leading the world in science and technology and in space exploration. And it eventually gets involved in world affairs, and there's an end to poverty, an end to war, and there's just world peace and progress and...a lot of space exploration.

There are studies that show that creative writing forms an important part of the recovery experience of people affected by serious mental illness (King et al., 2013; Kumar & Gent, 2013). He told me his gift of imagination and creative agency allow him to write stories of twelve or more pages in length in the short span of just a few hours. Edgar's first story envisions people with special powers that can be used to escape conflict; much in the same way his own imaginative powers allow him to overcome despair, loneliness, and childhood trauma. His second story then dreams of a better world without conflict, where everything works the way it is supposed to, and everyone finds their life fulfilling and meaningful.

As he was narrating to me these stories and his experiences of overcoming mental pain, I asked him if he had ever tried to access the mental health system to help him.

Edgar: Funny story, so I was just trying to play a game with someone, I was just joking with somebody and uh...and he said something that really hurt and I cried...it happened to be in the lobby of the residence building so a whole bunch of staff members saw me crying and that person felt sorry, one thing led to another and they recommended a therapist for me...he was employed at school...I told him a few things that were bothering me, I didn't tell him everything because if I felt I told him my parents were fighting, they might be in trouble for something. I told him how I was lonely and how I found it hard to...make friends, since everybody was so

divided...He offered to print out things like I could read. About...having relationships and...I don't really remember most of the stuff he said to me, to be honest...Yeah...I mean he offered to have another session but, of course he wanted...money for it...most of money of my health insurance card went to the therapy session. And...since the money ran out we couldn't continue the session until I paid for it.

Many mental health service users have to pay out of their own pockets to receive mental health treatment, such as medications, complementary therapies, or counselling (Neville, 2003). Although Edgar experienced a variety of frightening symptoms, the only interaction he had with a mental health professional was a counsellor who, wanting to be paid for his services, gave Edgar a list of pamphlets to help deal with his problems and then sent him on his way. We are left to question if Edgar's parents had the money to support him or if they were just unwilling to pay the extra fees. Edgar did not trust his counsellor enough to tell him 'everything', as many mental health service users—especially youth—need a great deal of time to build rapport before they can become open and honest (Brown et al., 2014).

After he told me this, I started to understand that he was someone who, perhaps in part because of his racialized status and financial worries, experienced the fundamental flaws of our mental health system. Racism and racialization have been known to impact the diagnostic process in the mental health system and lead to trauma, especially for Black men such as Edgar (Fernando, 1991, Keating, 2016). Edgar's story points to a sensitivity and power differences between psy-professionals and racialized service users (Delgado & Stefancic, 2003), which resulted in his distress being essentially ignored, unless he was willing to pay. Poole et al. (2012) argues that unmapping the connections between race and madness will shift the discourse of discrimination, fear, and danger, to that of rights accommodations. In this case, Edgar demonstrates a narrativizable agency that problematizes

the ignorance he encountered in the mental health system, and the distrust he felt towards his counsellor.

Still, while the mental health system may not have had a huge impact on Edgar's story, his resiliency was demonstrated by the coping mechanisms he invented to deal with his pain, and to escape a reality that was tormenting him day and night.

Edgar: For the most part, I feel like I've dealt with it. I mean...in regards to the relationships, I don't mind being alone. I find when I'm alone I think about great stuff, like great, great stories. In terms of my family, my parents fight. My mother's been telling me that she wants to separate with my father and I'm like it's her choice she can go ahead and do it. If he's not...giving her happiness, and if he's giving her despair, then she might as well do it...She wants me to be open. She tries. And every time I bring up something that happened in the past, between us, she gets sad and she cries and she's sorry. She wants me to talk to her more, she wants me to open up. It's painful for me to see my mother sad but...you know. Sometimes I find myself detached.

Edgar finds closure in his parent's possible and inevitable separation, despite it still haunting him and causing him some sorrow. He says that he has mostly dealt with his issues, but at the same time, he finds himself detached – a not entirely surprising state for a person who has had little chance to trust others or feel emotionally close with them. Some bruises in his mental health journey will not go away, and his emotional state is a delicate balance that seems only a little less worrisome because he is able to speak about his alternate reality rationally and openly. But Edgar continues to talk these problems out with his mother and acquaintances he meets such as myself. His situation is interesting: many people with less intense forms of mental illness are very involved with the mental health system, yet Edgar, who experiences an imagined reality and escape from daily life, has never had a significant interaction with it. And still he lives on, finding ways to think his way out of despair and loneliness. What exactly *is* real to Edgar is partially unknown based on what he told me, but we do know that whatever that is, it has brought relief in the intensities of painful

circumstances and darkness. We can call it madness, and/or we can call it inspiration and resiliency.

### *Daniel's Story*

Daniel is an undergraduate student who, like many other sociologists, cares deeply for marginalized populations, especially those who encounter homelessness. When I first met him, he struck me as a very compassionate and positive person with a lot of enthusiasm for mental health initiatives. I first heard about his community project, #TheoryOfLove, through an email forwarded to our department, and I decided to reach out to him to see if he would be interested in doing an interview. Similar to Edgar, his story begins with opening up about his experiences with bullying, which happened in part because of the way that he speaks.

Daniel: I'm not really stuttering now but I do have a stutter. Um...and it was a lot worse when I was younger I guess. But you know when I was in elementary school I was bullied... in grade 4 people were pretty mean at my stutter and also kind of made me feel inadequate with feeling like I can't measure up by talking. Like how other people talk, right? Um, I feel like my jokes weren't really jokes. Even though like in my head they were absolutely...hilarious but like when you stutter you're not the best comedian...Maybe because of my bullying I had challenges figuring out how I should interact in such a way so that I would be accepted and I'll be liked and stuff. And that kind of spurred my mental health challenges because you know if you don't fit in, you don't feel like you're valuable and all that stuff.

From an early age, Daniel encountered enmity from his peers because he talked differently than others. They saw his speech as a limitation, which in turn made Daniel feel like less of a person. As a result, he questioned whether he should continue to be who he really is, and started searching for an alternative identity that his peers would accept.

Quite often, narratives like these continue to spiral into a vortex of constant pain, despair, loneliness, and more difficulties in obtaining a social life. However, it is sometimes the case that one's disability can promote political empowerment and voice in a liberal model of citizenship that presumes and requires physical intellectual "ability" (Redley & Weinberg,

2007). Daniel's story, as we will learn, is full of redemption, political mobilization, and people who did help him along in his journey, which is a big reason why he never needed to access the mental health system. While Edgar might have benefitted from a more adequate response from others to help him deal with his condition, Daniel had the necessary support at home and had the opportunity to resolve conflicts with some of his friends.

Daniel: I remember these two people...at the end of the school year they realized that it wasn't cool what they were doing. And they wrote me...like apology cards. And were saying like that 'we shouldn't have done that to just fit in because you are a cool person'...I always try to think the best and I'm a pretty positive person even in all that. Those two instances really did solidify to me even when I was that young that like people aren't all bad or that people have good hearts.

The reconciliation Daniel experienced with two classmates solidified his belief that people can change and make amends, even after terrible instances of bullying. The apologies also started the process of healing that, for many mental health service users, has direct advantages when they carry their grievances with them for some time (Spandler & McKeown, 2017). Daniel held on to those beliefs as the bullying intensified in the later elementary grades, where fitting in and making friends became more and more challenging.

Daniel: In grade 7 and grade 8 it was kind of even worse. Um people were like super mean...I realized after my elementary school years that saying what's on my mind and being kind of myself wasn't the way to go because that's how I got bullied right?...There was this really mean guy, I remember one time he like was in like French class, he was sitting behind me and he was throwing erasers at me. I was really upset but I wasn't saying anything because the teacher was like teaching, and then this other guy turned around and like yelled at [the mean guy] right in the middle of the teacher talking which was awesome...And so then, I was almost like in tears because I was super upset but they were doing that, and it was kind of embarrassing that that was happening to me. And that the whole class was like watching...and then also I guess I was almost in tears just because of how sweet those guys were.

When I asked Daniel if he had ever reached out to any counsellors or family members about his struggles, he emphasized that his stoic desire for independence prevented him from fully opening up. He would tell his mom that everything was ok when she checked in, and even

though he was not fully honest, he still described his family as being a strong support system. Somewhat astonishingly, his compassion was growing more than his anger from being bullied, as he believed those experiences gave him a deeper empathy for his peers. The empathy he was building transcended expressions for individual persons, but rather was operating in a fluid and expressive network that encompassed everyone; both his friends and enemies (Beck, 2018).

That being said, Daniel still had to deal with the mental health repercussions of having little social life or support outside of the home.

Daniel: Basically I felt, um depressed and like I just didn't belong, like I didn't like have a group. So I felt very sad and very alone and very...yeah depressed. And feeling as though I wasn't valued. Because I wasn't valued right? I wasn't valued by my peers. I felt like these are people who don't understand me and I don't really understand them, right? And I think that yeah, it made me feel insecure about myself and about my abilities, like I felt I didn't measure up to the bar of where I was supposed to be at that period of my life. And I felt as though I couldn't talk about my insecurities and about the stuff that I think about in my bed. Like...when I'm not laughing and joking, I feel like I couldn't talk about my kind of vulnerabilities and my insecurities with these people because, they, wouldn't be supportive right? I kind of struggled with it alone...honestly I think I was ok with that because looking back it's kind of made me who I am now.

Daniel's identification with depression is directly related to his inability to express himself fully with others – especially the worries, fears, and insecurities that keep him up all night. To understand someone means that you have a close enough relationship with that person that you can become vulnerable. Since this openness was missing from his life, he felt that he did not understand anyone, even though he held on to an altruistic belief that people can be good. He had enough support in his life that he felt he could take on the burden of his pain mostly alone. But this left Daniel with an emptiness that he would later be filled by helping others, and becoming an ear to those who, like himself, suffered in silence and in fear.

Daniel: So it's a mental health project that I started (#TheoryOfLove). Um...the kind of premise is...we all have this desire to feel loved and to feel like we belong, right? And feel connected. And as I've just kind of explained in my own experiences, if we don't feel that way then mental health problems can occur. So um...you feel like you're not worthy and all that stuff. So I've started this project to kind of encourage people to talk about their mental health and what they don't talk about on social media typically. Which is mental health, which is vulnerability, and which is um...feeling inadequate which um...I think needs to be talked about more and which is the cause of lots of suicide, people feeling like they don't have connections and they aren't 'worth it' in quotes, like they are alone, right? But if we all talk about our vulnerabilities and people will realize that they aren't alone...I think that with a lot of young people social media is a good way to get this in people's minds and out there. So, I created a hashtag called #IAmReal and I'm encouraging people to go on social media, Facebook, Twitter, Instagram and use it and talk about their mental health and be just open and be honest and be vulnerable with like who they are.

The support I received from my family members and peers throughout my mental health journey made me realize that I was not alone in my suffering and recovery, so I agree with Daniel's belief that there is hope for others to offer support rather than rejection in the face of mental health issues. Daniel's message, built on an altruistic foundation, is that there is always someone out there who can help or listen to us. When people gain a better understanding of mental illness either through literature, observation, or experience, they are more likely to gain a sympathetic understanding of the pain that service users go through and an appreciation for their creative capacities (Koh & Shrimpton, 2014). Daniel turned what was a very painful experience with depression and bullying into a life mission to *be* that help in other people's lives. People experiencing homelessness and who have mental health issues are the ones we forget about most in society (Schutt & Goldfinger, 2011). Amidst the risks of engaging in random encounters with people on the streets, Daniel targets this population first as he sees this void as one of the most pressing to fill.

Daniel: I've met a bunch of people who have been homeless...I try to go around and interview people that are living on the street or in poverty, just ask them about their mental health...maybe um...they are a bit forgotten by like society. And what they want or well, need to see for the future...I've met uh this one person who said she's

homeless...when she's pan handling, so like asking for money on like the streets, with like a coffee cup or something...people wouldn't even like look at her, and walk briskly away because she felt she was a, quote, and I use the term very loosely because I think we all are, but like a 'crazy person'. I think that goes to show how...debilitating that social isolation can be. People like passing somebody by, right?...The project also helped me immensely because it helps me feel...connected like I have a purpose more than school or what have you...it to be honest makes me feel more comfortable because I think I'm like actually not alone right.

Daniel feels less alone when he meets people who have also felt deeply alone and in darkness. He identifies social isolation as a partial precursor to mental pain, and believes that when that feeling is replaced with support and camaraderie, it will start to be healed and give others hope that no matter their situation, they do in fact belong in this world and are valued human beings. Feeling this way would do much to combat the stigma around being mentally ill, because to feel 'crazy' is to feel not 'normal' and therefore become something of a leper in the broader community. Daniel overcomes this stigma by referring to a broader "purpose" in his community that is measured by a greater impact than what he tries to accomplish in school. On the streets, he is a bit of heroic figure for the time of day he gives to people struggling, whereas in school he was more prone to bullying and hostility, unappreciated for his efforts to make the world a better place.

Although Daniel's project is small, it is a big idea from a person with a big heart that has the potential to influence individual lives of people in his community. His project aside, Daniel also has a vision for the broader mental health and education system.

Daniel: I think the mental health system honestly needs the people in the power, or I think it needs frontline workers and governments who are actually making the decisions and making budget stuff, to be in closer consultation with people who are actually suffering. People who are actually challenged...The education of this and of the importance of taking care of yourself and taking care of other people, and like not bullying...people who are actually telling their stories and explaining why it's important to them. I think there would be a lot more open discussion. Um...I think that one of the main things that we need is like every elementary school and middle school and high school too should have a class dedicated to mental health...and not

like two or three weeks, but like a class maybe like once every two weeks or once every month, you know about mental health. And like a safe space where people can talk, and other students can talk about stuff. And I think that if more conversation gets encouraged and gets started and I think people, we'll feel way more open toward mental health and mental health challenges.

Daniel thinks the power of a story is strong enough to change people's hearts about mental illness and stigma. #TheoryOfLove is a testament to this power, as it has already had an impact on those forgotten in society who have a story to tell and be heard. If our education system likewise becomes more open minded to talk about mental illness on a regular basis, Daniel believes it would work against the bullying and forms of child abuse that precipitate a great deal of mental anguish. These ideas might seem almost obvious, or already spoken, but the fact remains that much of mental pain and illness happens in the dark, especially when we feel that others will simply not care about it, or judge us. The initiative Daniel has started is a weapon in the battle against such darkness and will continue to change and impact lives.

### *Clara's Story*

Clara is a bright graduate who holds a master's degree in the sciences, which she studied in part to better understand her own struggles with mental health. She grew up in rural Canada, and it was during a move in her childhood when she started to experience drastic changes in her life, and the onset of symptoms of anxiety and depression.

Clara: I would say like around grade 7 when I switched from elementary school to middle school, is when I noticed the biggest shift...So going from like a very close-knit small elementary school to having to branch off, make new friends, and that's when I started dealing with a lot more social isolation. I became like a different person within the first six months of just changing schools. I didn't really have any good friends anymore, people kind of went their separate ways and that's when I understood what mental illness meant, it made me interested to understand more like anxiety and depression. Going to a bigger school, teachers are not as aware of what's going on in the playground, and that's when I started experiencing bullying and social isolation from girls, and that was probably the hardest time of my life. And it's hard to talk with other people because even with like parents people don't know what to say or they can't understand because it's not something that's talked about...I've

always been a very outgoing like chatty social person. And then it's like these experiences completely destroyed all of that.

Changes of this magnitude in Clara's life – moving from her childhood home to a new school where she knew no one – meant changes to her mental health. With this mental pain came a desire to understand it better, and this sparked her to do her own Internet research on the symptoms she was experiencing. She told me she read much of the DSM, and got interested in neuroscience and psychology because she was now able to understand better how people “clicked”. For the remainder of high school, Clara would never see a professional but wanted to know what was going on in her mind on a deeper, more clinical level.

Like Daniel, her family was generally supportive of her and she described her house as being a ‘safe haven’ from the pain she was experiencing at school.

Clara: I'm so thankful that I had such a supportive household because that was like my safe haven. Like I would look forward to the second that bell would ring at the end of the day so I could go home...Because my grandma has Bipolar, so my mom was around it her whole life. She saw her in and out of the hospital. So like my dad never understood what it is, still to this day, has no idea, so I don't talk to him about it all. But my mom...was very empathetic toward it. There be a lot of days where like ‘mom I don't want to go to school’ and she'd drive me and she'd tried to get me, and I'd be like I don't want to go, just the anxiety, every single morning knowing it's another day to endure...Grade 9 and 10 is when it was full blown and, grade 10, I would say is probably the worst year for depression. I never saw a psychologist, I never saw anyone for it, but yeah I started speaking about my mom...asking like, ‘I'd love to go see someone’, I was like ‘it's getting really bad’, and we live in the country, so resources are next to none...there was nothing in regards to counselling, um...anything in the hospital, nothing mental health related whatsoever...honestly once I got to first year university that's when I started actually being like, you know what, I'm gonna go see someone now, you have campus resources.

Although her father had very little understanding of mental illness, her mother's experience caring for Clara's grandmother in times of distress gave her a deeper appreciation for her daughter's struggles. For others where the home is not a safe haven, such as Doug, Edgar, Zach, and Simon, navigating mental health concerns became more difficult, especially when

problems existed both at school and home. Still, the support of her mother was not enough to treat Clara's symptoms, as she wished she had more in terms of resources in the rural area where she lived. Rural areas often suffer from a lack of publicly funded mental health services (Smalley, 2010; Wilson et al., 2018). She grew up on a farm, so her parents had to work long hours during the day, and thus it would have been a burden to have to drive her into the city to seek adequate counselling and support. When she moved to the city and had access to resources because of the student fees she paid, Clara took the help that was available.

When we experience mental pain and illness, we are bound to experience many different feelings. Clara was not the only sibling battling mental health concerns, and she worried that her pain was not setting a good precedent for her brother and sister.

Clara: So all of us [two siblings] went through very similar experiences. Literally each one of us dealt with the bullying, the social isolation, the anxiety, the depression, like each one of us were spitting images of each other. Then I internalized a lot of guilt, I thought it is because of me. Did they all see these behaviours and then adapted to like my ways and stuff? So I felt a lot of guilt being the oldest, I'm like, I guess I wasn't a good enough role model because all of them have developed the exact same life experiences as me...My brother again being a guy, didn't talk about it till he literally went off to university. It was when he finally talked about, literally dropped him off at [university] and he's telling us these terrible things that have happened to him and I'm like, oh my god. Like...like dropping bombs, yeah. He's definitely more isolated when it comes to talking about any issues because again you know, the men in my family don't talk about anything because they don't understand, they sweep it under the rug, doesn't exist. My sister's been very open with me, my mom.

Gender divided Clara's household into those who talked about their feelings and those who did not. Certainly, conceptualizations of masculinity affect people's understanding of mental health and mental health services. Rowell (2016) found that having accessed services previously or having a family member discuss their own understandings of mental health impacted whether men constructed mental health and mental health services positively.

Clara's brother took after her dad and tried to develop a tougher exterior until he reached a distressful point where he needed to let everything out. Clara and her sister, on the other hand, regularly spoke to their mother and each other about their conditions, and that communicative process was instrumental in recovering and getting the courage to eventually finding appropriate resources. Hearing about their struggles, though, made Clara blame herself, as she took on a maternal role in relation to her brother and sister. This positioning heightened – and at times was the source of – her anxiety throughout her life because she wanted to protect her siblings from harm.

Clara: So I always held a lot of anxiety around my siblings. You know just feeling like I constantly need to protect them, worrying about their every move...this lingering anxiety around my brother and like losing him. Like I had a traumatic experience when I was young, we were just playing hide and seek but I couldn't find him...it was dark out, we're at the farm, like big open space. And that just set off for the next like twenty years of my life, this severe anxiety around losing him. So when this incident happened when I hadn't heard from him for like three days, and he hadn't had any activity on social media or anything like that, I...really feared the worst at that point...and it's like I need to cope with this once and for all. So that's what made decide to go see a therapist, it's like you know what, my coping strategies around this uncertainty were, were very unresolved.

Clara contemplated for several years if she had Post-traumatic Stress Disorder, and if this incident was the source of most of her anxiety. Sometimes, a higher socio-economic status can protect children who experience trauma for chronic illnesses later in life (Mock & Arai, 2011); however Clara's supportive family environment did not overshadow the distress she was experiencing. After enduring the anxiety for some time and having to deal with more social hostility, Clara finally decided to go and see a counsellor who was available at the university where she was studying.

Clara: I did it in second year, is when I started [seeing a counsellor]. Because I remember dealing with a very emotionally abusive roommate, it was really rough...just like the emotional abuse was starting, just like the manipulative behavior, the put downs and stuff...And then yeah I started going to see one of the counsellors

at health and counselling, didn't find it to be helpful whatsoever. I saw different people, and I saw males and honestly I was like, I don't really feel comfortable speaking with males a lot of time. I don't feel like I can open up. So then it wasn't until...fourth year that I saw a psychologist, um...I mean, it helped a bit, I found my friends to be the most helpful to talk about things with because one my friends who's going to be a psychologist now, she really knew like how to deal with just talking through...But I didn't...stick with [the services] long enough to notice much difference...it wasn't until just actually last year it's like you know what, I'm gonna go and work on like all of these sub issues that I've dealt with the last few years, and that to be honest I saw like a therapist for 10-11 sessions. And that is the most helpful, you have to see them for at least 10 sessions to really make a dent. And it was again going through all those past unresolved issues...those were the things that just weren't dealt with over the course of eight years.

Clara found her male counsellors to be intimidating, and the power dynamic created an atmosphere where she became more bottled up and unready to share aspects of her life that she needed to work on. As she told me this in the interview, I felt my presence as a man weighing on me, and I started reflecting on how I might come across in what was I felt was a sensitive discussion. I too found the tough-love approach given to me by my male psychiatrist after my first incident with psychosis to be intimidating and frustrating. Sometimes I felt he was more concerned about whether or not I was still smoking pot than the damaging side effects I told him I was experiencing from the medication.

While I felt some shame in hearing Clara's words, I also was grateful that my participants felt comfortable enough around me to divulge some of these tougher experiences. It was outside of a more formal setting that Clara found help from a student learning to become a mental health professional. She provided Clara with an empathetic ear, and ended up referring her to a psychologist whose practice she believed was highly recommendable. Clara thought that she would receive a label and diagnosis from these sessions, but that never occurred. Even without a label to help explain her pain, she still worked through some of her issues. I asked her what she thought about mental health

diagnoses, and if she agreed with the decision of her psychologist not to diagnose her with anything.

Clara: The problem is people self diagnosing and like my friend will always say, people will like embody their mental illness...you definitely see, people throwing around I'm so OCD, I'm so Bipolar, oh I'm anxious and depressed. So it's like even if you're not diagnosed, it's like oh I have that...I definitely think we are shifting toward more understanding of mental health but at the same time I feel...like especially in the case of ADHD, so overly diagnosed, and then even with anxiety and depression, working at [support centre], like sometimes you're not sure where there's a dividing line between, is it just your inability to cope with stress or is it a full blown mental illness?...And it's like blown up in some ways...because people have access to the information, oh I have this, and then they start to embody, like this is me...But what it comes down for a diagnosis is does it affect your everyday life, does it interfere with relationships, work and school? And if you're still high functioning like again, my school work was in check, everything...she [the psychologist] is like 'yes you might have the symptoms and there's area of your life and like you could improve with like therapy, but you don't necessarily have the diagnosis for the actual mental illness'. I was very shocked, like, all this whole time I thought for sure I could be diagnosed, she's like 'no, like you have some symptoms, that's about it'.

Clara problematizes people's leaning to self-diagnose and assume that symptoms of mental illness always equate to having a mental disorder. She believes the availability of information, and the communication of that information by patient to doctors, is partially responsible for the over-diagnosis of some mental disorders (see Giles & Newbold, 2011). Over-diagnosis for Attention Deficit Hyperactivity Disorder (ADHD) is a troubling and recognized phenomenon in the extant literature (Bruchmüller et al., 2012; Merten et al., 2017). She told me that many students are "coddled" at her support centre, and rather than being given the skills to cope, they are accommodated in ways that actually disempowers them and forces them to always accept that they are severely limited by their disability. Clara too felt the desire to be medicated as a "perfect" fix in high school, and it surprised her when she followed through with a counselling service that she did not receive a diagnosis. This demonstrates that some mental health professionals also have an awareness of the

problematic tendency to label states of mind as pathological when in fact it may not be necessary to treating the symptoms.

Of course, this is also a precarious rope to walk when the risk of someone having a severe and undiagnosed mental disorder can put lives at risk. As my story indicates, my life was threatened by the inability of doctors to realize that I was psychotic, and to treat me accordingly. This happened to me a second time in March of 2018, when I could not convince two doctors, likely because my rational state of mind had not yet fully collapsed, that I was starting to incur psychotic symptoms again. Finally, at an emergency clinic, I found a psychiatrist who would listen to me and then I was treated promptly and appropriately for my disorder. Clara's experience points to the thresholds that make mental health diagnosis so frustrating and difficult to pin down, which is why we need service users and caregivers at every level in the mental health profession to work with one another to find out what the best approach to care is for each individual.

Clara's work experience helped her see that she was not alone, as there were many clients that went through their programs who had to deal with issues close to her heart and that were all too familiar.

Clara: To see people you know, of all different types, who have all different types of disabilities, it just really gave me a lot of awareness of what's out there and how prevalent, and that's not even skimming the surface of what's out there, these are people who are like actually, you know, self-reporting. There's so many people out there that haven't come forward, they're suffering. So being around that environment really made me feel like ok, yeah, there are a lot of people out there who are going through it.

In addition to gaining a broader awareness of what is out there in terms of mental pain, Clara also has ideas about how to target mental health before it turns into illness.

Clara: What I think is it definitely needs to start at a younger age. I think teachers need to be much more well equipped with just a lot more in-depth mental health

training, especially in the elementary school, because you know bullying is starting very young. There needs to be like, people, to step in more. I hate this whole mentality of like, change only comes when something bad happens. Someone has to die for a new law to be implemented... Starting that like, six, eight years old where people all of a sudden are feeling suicidal in school and I'm like this is, this is not right... Let's understand what mental illness is, let's talk about you know the symptoms, let's talk about how we can improve, let's talk about resources that are out there for parents and for students, not just like Bell let's Talk, let's talk about this one day, like big whoop. People talk for one day and all of a sudden, the rest of the year it's forgotten, people go back to their regular ways. And definitely introduce more resources in schools, more counsellors, I don't even really know what's going on in the school system, like getting to university and all of a sudden like it's a full-blown epidemic. It's insane.

Clara's story departs on the message that seriously talking about mental illness has to be an ongoing, daily exercise, especially with children who are more prone to it because of their family or school life. Like Daniel, she believes our institutions can do much to improve the lives of service users and prevent mental illness and pain if they are provided with the adequate resources, and become more serious about educating youth about the circumstances, treatment, and symptoms surrounding mental illness. To her, mental health is reactive right now, meaning no one tends to speak out about it until something has happened or it is already too late. Preventative mental health means educating others about what is out there and what could happen to them so they have a better awareness of the resources available.

### *Heather's Story*

Heather studies the sciences at the undergraduate level, wants to get accepted into medical school, and then hopes to one day become a neurosurgeon. She worries about her GPA and the high standards placed on students wanting to get into this profession. If she does get accepted, she worries about financing her education. Her parents refused to provide her with any financial support because they figured that if she spent her own money they

would not be as disappointed if she flunked out. She experiences Anxiety and Depression.

Like many of the other service users in this dissertation, her story begins with social and identity struggles during her adolescence.

Heather: Probably middle school, so like grade 7, you're a lot more on your own. When you're in the younger grades you really don't care about anyone, I'm just gonna do my thing, I don't really care, and like middle school you're like oh, ok, well now I start to care what other people think. I had my group, I was never like popular. But I had to start over [after moving]. None of my friends came to the same school as me. So like I had just me...my brother has Asperger's. So my parents were dealing with him and then I was just doing my thing cuz like they had to put all their attention on [brother]... every time someone would like try to talk to me, I'd be like oh I said the wrong thing. Now they don't like me. I guess I never really knew what it was, anxiety in the sense that you overthink everything...and because you have the depression on top of it they must thinking all these bad things.

Heather told me that moving to a larger school forced her to find a safe and secure in-crowd while her parents cared for her brother who was on the autism spectrum. Eventually, these feelings of insecurity became pathological, and Heather developed intense symptoms of Anxiety and Depression. She told me her friends did not take her experiences seriously, and were not mature enough to understand the difficulties these challenges presented to a student.

Eventually, her parents 'found out' about her struggles, and although I did not probe around that circumstance for fear of causing her to relive what might have been traumatic events, I got the feeling that a major incident happened at school.

Heather: Then my parents found out. And then I got a psychologist...there was one point where like, it wasn't a wilful open up it was...they found out...like grade 7 to like the end of high school, I had a lot of deaths in the family. Uncles, aunts, grandparents. Yeah, so it was like constant and probably made it worse. [Going to the psychologist] made my parents feel better...near the end of high school, we got a psychiatrist, so I moved from like psychologist to a psychiatrist because [psychologist] can't prescribe medication. So...we had to find someone who could do that. Well and then when I started getting into like an actual of crowd of people that I would like to hang out with, my parents weren't very supportive. Like I wasn't able to go out anywhere, do anything. Like they were very strict with school.... I would be punished severely...and, when I was in high school I had two jobs as well. So like

they really didn't want me going out and...doing my own thing...I ran away a couple of times.

Heather's life became harder and harder as she reached adolescence. She also explained to me that she had to deal with many deaths in family; navigate the frustrating demands of her strict and punitive parents; work two part-time jobs; maintain her A average in school so that she would get accepted into university; support her brother who was being belittled by his peers because of his condition, and try to have a social life despite not being permitted to hang out with her friends very often. It is no wonder that she started to feel depressed and anxious about the present and future. Despite the tough household environment she describes, when her parents became aware of these issues, they took her to a doctor. Her psychiatrist, whose primary role is to issue medication and diagnose mental illness, prescribed several different drugs as time went on.

Heather: I went through a lot of different types [of medications] and I got tired of going through them, so I was like yeah sure this one is fine. Cuz every time you have to get blood tests, and I was like I don't want to do this anymore...I mean they gotta be doing something because I know when I forget, you feel that you forgot, 'oh crap, crap', but like the only thing is it sucks cuz like you can't like drink [alcohol] with them. It doesn't work, that day. So um...it's kind of like not taking them for a day.

Matthew: Do you think you need the pills to function though?

Heather: No but my psychiatrist says he doesn't want to take me off them until I'm done my undergrad...I don't really care...I just think the assigning of drugs, I think they gotta make that easier. Like...having to go through that amount of work to change your medicine and stuff like that.

It is very common for someone starting psychiatric medication to have to work through a long list until they find one that both eases their symptoms and has minimal side effects. It took Heather two years to find a medication that did not give her massive side effects such as terrible night terrors, light-headedness, insomnia, and loss of appetite. What is interesting in this narrative is that Heather was very minimalist in her expectations of a relationship with

the psychiatrist. She only knows that the medication is having an effect on her Depression because she feels Anxiety when she forgets to take it, and still this understanding of the drug is enough for her to agree to take it because she defers, to some extent, to the authority of her doctor. Her story intersects with Morant et al.'s (2016) reports of service users who felt uninvolved in medication decisions and unable to relay their concerns about their potential adverse effects. Though in this case, Heather is less concerned with the micro-social aspects that shape why shared decision-making in psychiatric diagnosis and prescription remains a rarity.

Heather told me later in the interview that she does desire to get off of the medication, but is essentially ok with taking it for now because she has so much on her plate, and trying to taper off a drug would just add to the burden. Her primary concern of getting into medical school weighed on her mind a great deal throughout our conversation.

Heather: For my goal of wanting to get into the medical field, they made it pretty difficult for someone's who's struggling with that. Because like you're already dealing with all this and then you have to worry about grades and then especially if you have anxiety, it just adds to it. And...it like is basically impossible for you to become a doctor if you have anxiety. They make it pretty much impossible because the standards that you have to be held is insane...Like I think to get in, you have to have a 3.9 GPA on a 4.0 scale. And then, also the money. So like...someone like me who's supporting myself to get through university. And then...they're like, well you gotta take the MCAT which is 700 dollars. And you gotta take your classes, like that helps you understand the information to get into medical school, and then you have your tuition for medical school. So like...there's no way. There's no way you can afford that.

Even though the medical profession is responsible for helping students receive accommodations for their conditions and illnesses, Heather believes it has a long way to go in terms of how it produces and acclimatizes future physicians. The text above makes me anxious both reading and listening to it. I am reminded of my own fears of landing a permanent position in academia, and how hard one has to work to achieve that goal amidst

serious mental health issues. It is only within the last couple of decades that conceptual approaches for vocational rehabilitation and supported employment for people with serious mental illnesses have been driven forward by social workers and scholars (Becker & Drake, 2003; Corbière et al., 2011), but some of these programs focus more on getting any kind of employment rather than meaningful employment. One of the reasons that Heather is so anxious about finishing school and landing a job she wants is because she feels that part of her condition is treated insufficiently by her doctor.

Heather: I still have the anxiety, cuz the thing with...the medicine is you gotta pick, they treat the Depression or they treat the Anxiety. So they wanted to treat the Depression because that was more serious than Anxiety so I gotta live with the Anxiety...I mean, I'm sure the drugs are doing something for the Depression, like, it would be nice if it could help the Anxiety...the Depression makes you unmotivated to do stuff. So if I'm overwhelmed, like right now I'm overwhelmed...so like...I'll just not do anything because I don't want to deal with it...But then having the Anxiety you're thinking about it and you're like well I have so much to do. And I put it off because I didn't want to deal with it, so it's just like...it's...they don't go well with each other.

Heather wishes she had more autonomy in the decision-making process of her treatment (Morant et al., 2016). She believes that Anxiety is the root of her medical issues, while her doctors want to treat her Depression instead because they are thinking in terms of risks. Will she become suicidal? But Heather believes that Anxiety and Depression are not mutually exclusive categories. Her Anxiety affects and brings on her Depression, and her Depression makes her Anxious. So refusing to treat her Anxiety, in her eyes, makes the treatment ineffective because it is not attacking part of the source of her problems. While doctors must think about risks and weigh these considerations seriously before they prescribe medication, Heather's expertise on her own condition (see Kirmayer, 2000) could provide doctors with some important and profound insights into how *she* experiences the illness.

She went on to tell me that they should consider classifying Depression and Anxiety as one interactive label, rather than separate it, based on her understanding of it. But this insight weighs on her inclination towards trusting the medical profession – the very trust she hopes to one-day build with other patients.

Heather: I feel like...people don't think of it as a serious illness...but it should be actually be taken pretty seriously. People don't see it that way. Depression, probably [the doctors] took it a lot more seriously, but anxiety they don't. They don't care. I mean...there's some people who need it. And it shouldn't be taken [as something that they can deal with] on their own. And there's other people who, who could totally deal with it on your own and probably would be better off. So it's hard to say... Now that I'm older I know it's not, it's not gonna change. So it's...it's just something that's just gonna be there.

Because Heather is older and her brain has essentially finished its development, she laments that she is going to struggle with Anxiety-Depression for the rest of her life. If she does not get accepted into medical school, Heather plans to do a master's degree, and I wonder if she will produce research on Depression and Anxiety that speaks more to the pain she experienced. When I asked her how the mental health system could improve from short exchanges with specialists to an environment where patient knowledges and concerns are invited, taken more seriously, and not judged, she pinned the problem on the way that psychiatrists and psychologists are recruited and trained.

Heather: Like they're always tight for psychiatrists. Their waiting lists are always really long but yet when people try, to get the degree to be a psychiatrist or psychologist, they make it extremely difficult to get it. So, I mean I get that you have to be good at what you do, but to make it impossible to get to that point...no wonder there's so many not being treated, there's not enough people to treat them. But when people try to go down that road to be someone like that, it takes forever, or it's just, it's not feasible or something like that...I think that psychologists and psychiatrists shouldn't be two separate visits, I think they should be in the same room. A psychologist is listening to what you're saying, and [the psychiatrist] is taking that information and prescribing medication, both can incorporate into one and I think the medication will be a lot better diagnosed...Maybe I'd be treated for Anxiety instead.

Heather dreams of a mental health interaction that bridges the expertise of several mental health professionals into one session (see Younes et al., 2005). This might debunk some of the power imbalances that prevent some patients from getting at the heart of their issues. She identifies ‘listening’ as a key to mental health treatment, and feels psychologists could use the information they learn from the patients voices to inform psychiatrists’ prescription of medication more often and more directly. Moreover, we need more people on board in the fight for mental health, and this might mean making the requirements to get into this profession more realistic. Heather feels that there are many qualified candidates who cannot get into the practice because of concerns that have nothing to do with their abilities, and remedying some of these administrative barriers would take some of the burden off the mental health system. Given her passion and insights, it is my hope that Heather becomes one of the lucky few to overcome all of these obstacles.

### *Hannah’s Story*

Hannah is a determined undergraduate student who just landed a part time research assistant position in the sciences. She wants to do advocacy work and research in the field of mental health to give back to her community. When we met, I interpreted her as very mild-mannered, shy, but also forthcoming about her experiences with the mental health system. Her story begins during adolescence when she started to experience Depression and an Eating Disorder.

Hannah: It started when I was really young but I just never really recognized it as problematic. My parents when I was growing up were pretty intense in terms of like you know, ‘you have to achieve’, you have to be like ‘this great at everything’. So I would do things a certain way and stress out when things weren’t exactly right and stuff. Which is probably not the way that you should be as a kid. But I never fully like, entered the system of the mental health care until I was 16. High school was not great...I don’t know if you know how like girls can be in high school, it’s not awesome. I felt isolated I guess from people around me...So I dealt with it by like,

school focus but also like food was a thing that I would focus on and like exercise and stuff. Um, so that started when I was like twelve and thirteen, I was just confused like maybe something is wrong because I'm fat, it's stupid but that was what happened... In grade 11, things got really bad and I lost another 15 pounds... I would wear kid's clothes and they still couldn't fit. My mom was pretty worried. I kind of knew I wasn't doing well, like I would just kind of sit beside the fireplace and stuff and not really always be able to form sentences, my brain wasn't able to do the stuff it needed to. So then I was in the hospital for quite a while. And at that time that was when [the mental health professionals] were like 'oh you actually have Depression, you do have an Eating Disorder' and stuff. And I was kind of surprised and I just never really thought it was that...

Like most of the participants in this study, Hannah struggled to find adequate social support at school, which led to her becoming isolated. She also was challenged to do well in school. Trying to bring out the best in one's child is not necessarily a bad thing, and as Simon mentioned earlier, stress can actually be productive in some cases. Yet we have learned in this research that high parental pressure seems to interact in some ways with the development of mental illnesses. It is also common for those with Anorexia Nervosa to be high achievers (Gulliksen et al., 2017). Having a supportive family though, Hannah was taken to a hospital to receive treatment. She spent a month in in-patient care in a children's section of the hospital, and then was in outpatient care, about three times a week for approximately two years. She got care from a number of different professionals, and I asked her what her relationship was like with them.

Hannah: At first, I just didn't talk at all, like I would literally just sit and not say anything, or I would get really mad sometimes too. Because they were so like matter of fact about everything so sometimes I would get so angry and I would yell... I don't get angry too easily, but yeah, so they must of thought I was nuts. After maybe a couple of months I started feeling like better about it, like I would be like ok I can't wait for it.

Going to the hospital for the first time for mental health issues is not a fun event. Under conditions of extreme paranoia and hallucinations, I found the environment to be very annoying and frightening, as there are many people there in distress who at the same time are

trying to socialize with other patients. In Hannah's case, she found the professionals' direct forms of questioning came across as intimidating and aggravating. She had outbursts of anger to relieve her frustrations, and felt a stigma that expressing her emotions that way must have presented as crazy and deviant to others (see Thoits, 2012).

She recalls that as her hospital stay lengthened, however, she settled into her environment and began to experience some benefits from the treatment.

Hannah: I actually found it amazing. They were so good, they had a whole like unit for Eating Disorder specifically. But they didn't just deal with like the food cuz it's not really about the food anyways it's about, like you know, you're trying to control your life or deal with things you can't control. So they were really great, like helped me pick apart why I was like doing certain things I didn't even know. So I actually got like fully better and it was awesome...[My family] would stay with me at meals and after too. And like we would do a lot of like puzzles and stuff after meals and it was just like, that actually I think kind of made me feel closer to my family cuz...it like...I had been so like, isolated and like the Depression and stuff that I just didn't even have relationships with anybody really. And so that was kind of a type of also...like, getting to know them and stuff. Yeah it was incredible, like not that I'd ever want to go through that again but a lot of good has come out of it I guess.

It is not always the case that times of distress can bring families closer together. Like Hannah, I too felt the love of my family – my wife, mother, father, and brother – during my acute period of sickness. My parents allowed me and my wife to stay with them while I recovered, and my wife supported us financially. My brother would visit regularly and play video games with me, and this was essential, since I had left British Columbia and my peer network, and really needed a friend in my life. Parents, too, can experience stigma during their children's hospitalization, or they can find that event to bring their families together in a supportive way (Foster et al., 2018). Hannah's parents and siblings visited her often, and the support they gave her replaced the void in her life that was causing her to feel secluded and lonely. During this period of support, she also started to gain an awareness of her disorder, and some of the feelings and underlying problems that often precipitate disordered eating.

She describes her Eating Disorder as being a way to control other aspects of her life – situations and circumstances that may have caused her to feel powerless and a need to replace that with a sense of control.

After recovering for two years, Hannah turned eighteen and received a scholarship to attend university. Her doctors were worried about her decision to leave her community since they believed she was still in a fragile state. Hannah still decided to go to university, and there she met a group of friends she described as being her “family away from family.” Her first two years went very well, she succeeded in her classes and enjoyed her social life. She also found having a solid group of friends to help her continue to manage her eating disorder.

Hannah: The other thing is too, seeing, like living in a community of young people and going to the caf and stuff it kind of...helped me learn how normal people eat and live and, you know, kind of like, what normal is supposed to look like. Which helped a lot...And it would be like ok everyone’s going for lunch so I would have lunch whereas like if it was just me I wouldn’t have maybe done that. So that was awesome. So first year and second year were pretty good. Um this past year was not...just a lot of like life difficult things happened. Um, just different things like over last summer and stuff I kind of had a bit of a relapse with the Depression, so that was...hard because you feel like ok I’m better now so I should be better forever and then it comes back and you’re like...more hopeless almost than the first time because...you think ok I’ve dealt with this now and it’s over. But I hadn’t been really seeing anybody or been followed at all those two years so I guess I kind of set myself up for it.

Eating Disorder communities can either reinforce unhealthy eating habits, or support efforts to recover from the disease (Wang et al., 2018). Learning through example, Hannah’s community helped her develop healthy eating habits. Having a better social life, university life allowed her to focus some of her attention on what others around her were doing, and she used these observations to alter her routine. Yet since she was away from home, she did not have the continued support from the caregivers who followed her from the outset of her mental health journey. Hannah’s first relapse made her feel like something was wrong with

her, or that she did something wrong because she had discharged herself from care. She also struggled to continue taking the medication she was prescribed in hospital.

Hannah: So they put me on not the highest dose when I was in the hospital because I was like very depressed. But then they never took me off of it. And so I tried two summers in a row, like the summer after first year and second year to reduce it, cuz I didn't want to be on it anymore. And I was, just going down this really small mound, it was like back into the darkness and so I got really scared...So I went back up but then this past semester I was pretty, pretty low. So they put me on an even higher dose. And I think I like, I don't know if overdose is the right word but it was not good. I would get really dizzy and I was only on that higher dose for like a week because I was like...half-way conscious, I'd be kind of feeling like I was in a dream all the time, so that was really scary. And so I was like, if it does that at this dose, then it's probably doing weird stuff even if it's at a lower dose than I'm tolerating. So now I'm almost off of it. And I'm at like the lowest possible dose you can take. They actually wanted me to put me up the next highest class of medication, which has like a wackload of side effects. And so I was like no, what are my other options because I don't want to do that unless that's a last resort and they're like 'ok, well we'll try a higher dose of the SSRI that you're on and then um...if that doesn't work then you go up to the next one'. So...yeah, so...I guess I did have a say in it but...

Hannah was agential in the sense that she played around with the doses of medication, hoping that she would not have to stay on the pills forever. But the first time she lowered the dose, she hit a low, and then had the mindfulness to go back to her regular dose. This time around though, the medication was not enough to stop her from hitting a depressive state that prompted her doctors to increase her medication to levels she could not tolerate. It could be the case that Hannah was over-prescribed medication, as the side effects of the drug started to take away her grip on reality. When she was presented with the option of going on a more potent drug, Hannah chose to decline their recommendation and her decision to take a higher dose of the drug she was currently taking was respected, but this seemed like quite a small victory considering she was not enjoying her treatment and also wanted to find a way to deal with her depression without resorting to medication.

Caught in a bit of a catch-22, Hannah made the decision again to taper herself off her medication. She did not consult a doctor about doing this, but her family supported the decision and encouraged her to do it.

Hannah: Since I've reduced my dose quite a bit, it was such a weird thing but I was looking at my bank card to enter it online and I only had to look at it and then I entered it and I was like wait, for the past four years that I'd been on this medication, I wouldn't be able to look at those numbers and remember them to type them in after...And it's kind of scary. My mom always kind of thought that medication wasn't the answer so much...She was like you know, this is something you need to do for yourself, so she was the one who kind of encouraged me because I was kind of nervous about it. Yeah...I don't think medication is gonna be something I, like I think I will have times when things come back...and I think that's kind of natural once you've been through it that you know you're not just gonna be free from a depressive episode for the rest of your life.

Hannah's relationship with the medication was always tenuous, as she had to constantly weigh the risks of being very depressed against what she knew the drugs were doing to her body. Sometimes family members can become very scared about these risks too, and would err on the side of medication compliance, even though some results indicate that family can play a limited role in medication adherence (Tharani et al., 2013; Zygmunt et al., 2002). However Hannah's family also felt that the drugs might be a Band-Aid solution that was preventing her from living her life fully. Her mother especially encouraged her to try and live without the drugs, and since then Hannah has been able to manage her life without meds. She is aware, however, that she is not immune to another depressive attack, in which case she may have to go back on medication. Yet she is empowered to take the decision to be treated or not into her own hands, weighing the advice of doctors with her own gut feelings and perspectives from her family. This was not something she recommended to other mental health service users, but it was rather something she had to do for herself.

Like many other service users in this project, Hannah did share some advice for people going through similar battles with mental health, and recommendations for the mental health system at large.

Hannah: I would probably say the biggest thing is like...to just focus on taking the next breath. That's something that helped me especially when I'm having really bad days and stuff, you look so far ahead and you're like I can't even live through another day I just can't do this again. But if you just take it like...I'm just gonna do one more breath and after that you get to the next breath after that and you just keep going. And then eventually, the pain ends and, and good things happen, then you recognize that like you wouldn't have gotten the chance to do any of those things if you had not taken the next breath you know? It's just hard to recognize that when you're in it...

Beyond these personal recommendations to help those falling down a tunnel of despair to get through another day, she also outlined some issues she sees in the broader mental health system.

Hannah: And I don't think there's enough communication between care people, it seems sometimes you go to your psychiatrist for some things for drugs. You go to your psychologist for talking about things but only once every month because they don't have time...there's so many things that don't get to the people who need it...And it's so hard to even just seek out the help and then to be like looking for and not able to find it. When you're already feeling really helpless it's just...I don't think that should be happening and I think that, that this system is, is failing a lot of people...If you're not helping people who are struggling with depression and like suicidal ideation and stuff, to be told 'oh sorry this is the best thing we can do' is...it's dangerous. I don't think that's the best that we as a society we can do for people in mental health, I think there needs to be like changes. But I don't know what that would look like, that's what I'm struggling with right now.

Hannah also acknowledged how hard it is to talk openly about mental health issues, and that she has difficulty fully trusting people. But the more we talk about it, the more comfortable we get, and she believes that starting these conversations and sharing stories about mental health will work towards social change. Sometimes just sharing our pain with others is a part of that 'next breath' Hannah identifies as integral to getting through those days where it is difficult to imagine living at all. She leaves us without any specific blueprint of what a

mental health system might actually look like when it takes care of its ‘lost sheep’, but her passionate plea to help the people who feel isolated and are without care is a reminder that our system can keep improving, amidst all its changes and problems, as long as the vision is there and service users are heard.

### *Chapter Summary*

Persons labeled as mentally ill can be perceived as less than human (Goffman, 1961). Supporters of labeling theory indicate that the label rather than the condition per se compromises their life situation, while critics believe that the severity of the illness and their treatment shape their fate more than extra-illness factors (Rosenfield, 1997). Some people may engage in label avoidance and not pursue mental health services because they do not want the prejudice or hardship that such a label enacts (Ben-Zeev et al., 2010). In other cases, being diagnosed with a mental illness can improve their social safety net, as family members and friends may increase their support and involvement with that person because they might perceive them as having less control over their life, situation, and illness (Corrigan et al., 2003; Perry, 2011).

There are many differences in the ways in which men, women, and gendered Others construct the meanings and personal evaluations of their mental illness labels and treatments (Blum & Stracuzzi, 2004). People can both implement varying degrees of agency or communion with caregivers in response to mental health treatment and discourses (Chivon et al., 2018). Some research suggests that people who actively resist their mental health label because of its associated stigma (Thoits, 1985), but still show some willingness to value their caregivers’ treatment and methods, receive more positive mental health outcomes than others who fall on the extreme of either spectrum (Gilbert, 1981). More specifically, agential

experiences can ease some of the self-esteem issues related to being diagnosed with a mental illness and lead people to have higher life satisfaction (Rosenfield, 1997), while communion is important to seeking social and professional support in times of distress (Chivon et al., 2018). Educational interventions to reduce stigma may also help foster humanizing and empathetic relationships between care providers and patients, not to mention aid in equalizing the power dynamics between them (Sukhera et al., 2017).

We saw many critiques mobilized with respect to the labeling of mental health issues in this chapter. Heather believes that because Depression and Anxiety are so over-diagnosed, people in the community do not take these illnesses seriously enough. Based on her subjective experiences with the condition, she also raise concerns that the research on the illness may not be up to date, as professionals' leanings towards treating Depression over Anxiety instead of together may not be getting at the root of the pathology. The intense power dynamics between patients and caregivers prevented her from sharing this opinion in a serious way. For the sake of just moving on, Heather chose to defer to the authority and decisions of her doctors to keep treating her Depression.

Although Hannah accepted her label of Depression and an Eating Disorder, she needed to take her treatment into her own hands by eventually withdrawing from medications. She felt that she was being overprescribed anti-depressant medication when she experienced a low, and this gave her terrible side effects. She reached out to her family about desisting from taking medication, and they supported her decision. She could never admit to her doctors she was choosing to do this, as it was just something she had to do for herself, even alongside the risks. Both Hannah and Heather's stories demonstrate why studies such as these are so important, as creating a safe space for service users to let their voices be heard

outside of a clinical setting can get at experiences that are more difficult to share under the scrutiny of a psychological microscope (Burstow, 2016; LeFrançois et al., 2013).

Edgar's interaction with the mental health system consisted of a brief encounter. We are led to question if his status as an immigrant and racialized minority shaped the almost complete lack of intervention. This absent response from the formal mental health system, combined with constant bullying from his peers, and experiences with domestic violence accumulated to the extent that Edgar developed surreal tendencies to escape his pain. It is never a happy case to see someone else deal with their pain alone, but Edgar's story reinforces other studies that document how service users overcome mental illness with very little formal support, and how those very supports can sometimes do more harm than good (Farber, 1993, 2013).

Daniel, on the other hand, never accessed the mental health system because he (and others around him) never felt he needed to. The people who caused him pain redeemed themselves on occasion by reaching out to him, and this gave him the necessary strength to manage his depression and lack of a social life. His story, alongside Hannah's, demonstrates that when mental health service users have the necessary social and family support, their chances at recovering and gaining stability are higher (Jivanjee & Kruzich, 2011; Leggatt & Woodhead, 2016).

Clara, however, who also described her home as a kind of 'safe haven', still needed to venture outside the love and support she got in her family to deal with her problems. Her rural location at first was a barrier to treatment (Smalley, 2010; Wilson et al., 2018), but when she moved to the city to attend university she gained the strength to confront the issues and past traumas that were haunting her. While she found male counsellors to be intimidating

(Coleman & Pope-Davis, 2001; Taylor, 1994), she eventually found a female psychologist who listened to her and helped her work through her problems without the need for an official diagnosis or referral to a psychiatrist. She initially wanted a label that would give a name to her constant pain, but eventually agreed with the psychologist's decision not to give her a diagnosis. Based on her work experience, she recognized over-diagnosis as a weakness and abuse in the mental health system (Phelps, 2013; Merten et al., 2017), and believes that over-labeling mental health problems is disempowering some service users to cope adequately with their conditions.

This finding contrasts the narratives of Doug and Zach who both found a great deal of meaning in their label. Their illnesses were very serious and the label gave them some explanation as to why life and school had been so challenging for them. It is thus imperative to view service user critiques through a micro-political lens that works in relation with other narratives that nuance such criticisms (Newman, 2016), and acknowledge the many tensions in trying to make claims about something that is ridden with so much complexity and digression.

## **CHAPTER 9: CONCLUSION**

### *Post-Anarchist Implications*

I would like to begin this conclusion with a brief consideration on the importance of the social form generated by the service users' stories for any critical exegesis of psychiatric practice. It was never my intention to examine how 'effective' our resistances and agency were in redirecting power relations between patients and mental health professionals. Surely such conclusions could be reached if the psychiatrists were interviewed and asked how patient perspectives, dissents, and behaviours (re)shape their understandings of their profession and medical responsibilities.

My focus, rather, has been an attempt to concentrate on how the service users circulate narratives that enable them to establish their own forms of self-identity outside of clinical settings. It now becomes necessary to address these narratives critically and to question the efficacy of our encounters and interactions. I ask, how and to what end do these narratives facilitate the understanding of users as autonomous subjects enacting political resistance?

My engagement has centered on the question of agency and the propriety of a post-anarchist frame for grounding critiques of psychiatric power. Such an approach has obvious political implications. To question the validity of psychiatric professionals' power to compel forms of treatment upon those experiencing mental illness, is to question the validity of the medico-judiciary apparatus which supports it (Chandler, 2014; Federman, 2012; McSherry & Weller, 2010; Peay, 2003; Szasz, 1989). Questioning the link between the medical and judicial is a question of the propriety of such institutional arrangements and therefore a question of politics. Yet, post-anarchism offers a different view of political engagement than

is typically acknowledged in sociology, particularly its Marxist and phenomenological circles. I have not sought to privilege the experiences of service users by granting them the status of the ‘real’ or ‘actual’ while the medical-diagnostic is the ‘imaginary’ or ideological (see Farber, 1993). Post-anarchism rejects placing certain forms of identity (not to be conflated with experience), and by extension those who possess them, in the vanguard in the political fight for autonomy and self-actualization. Post-anarchism is rather a position grounded in a non-foundational account of power and politics where “essential identities and fixed normative categories are destabilised” (Newman, 2016, p. 285). How this position is different than a post-modern perspective is that even though essential identities are rejected, experience is not. Experience does not have to be grounded in conceptualizations of the individual. Post-anarchism tries to construct a novel account of experience that is rooted in new forms of singularity that are not individualistic. It goes further than classical anarchism by rejecting any fixed normative assertions about individuals.

But in privileging the forms of experience recounted by service users on less realist grounds, I have sought to examine the manners by which they relate their experiences and attempt to establish forms of identification at a distance from psychiatric providers. In addition to my earlier question, ‘what agency should service users be afforded?’, it is clear now that I need to pose another: what forms of agency are actually being expressed? And further, do these forms facilitate critical engagement with psychiatric power? Importantly, most of the respondents do not really advance stable political positions, and for the most part, nor do they suggest the sort of concrete institutional arrangements that would constitute a political critique. Further, their narratives are generally not appeals to their personal knowledge as though their own experiences should take precedence over the medical

diagnoses of the psychiatric provider. In some instances, appeals are made to medical knowledge in a contest over psychiatric power, but these are problems of definition, not politics. Rather, at the levels of both form and content, the narratives describe concerted attempts to *affirm* autonomous practices in the ‘here and now’ (Newman, 2016) and to *destabilize* the interpellative hail – in the Marxist sense of the term – of medical professionals.

A post-anarchist position does not rely on the necessary identification of the political subject with the identification of a more fundamental subjectivity rooted in liberal humanism or existentialism for example, but with the *affirmation* of the practices refusing representation. What Newman (2016) is saying is that we need to focus on how people construct forms of identity and community. They create a type of social system wherein forms of subjectification are interdependent and therefore the forms of experience connected to them do not necessarily have to be first hand or ‘experiential’ in the sort of naive realist sense. This position is still, to some extent, structural, and that is why it is different than a post-modern conception. There are still structural effects of a social totality on the means and mechanisms we take in our resistance. We cannot simply rebel in a world that expects that of us. We need to tailor our mechanisms of resistance against the forms that are challengeable.

It is in the act of contesting their interpellation by the psychiatric apparatus where we get a glimpse of post-anarchist critique. Elaborating once again by contrapositive, the post-anarchism approach proposed here is not so much a variant of standpoint politics. At its most problematic, identity politics in the Mad Movement – the struggle for representation or rights by a particular marginalized – presumes that those in the role of the dominated understand domination best. But does this not, to some extent, contribute to the glorification of

domination? Yet it is precisely the basic gesture of identification via substantive categories of existence that post-anarchism challenges, what I have referred to earlier as a withdrawal from the game of power. Here again we can see a post-anarchist agency being exercised. Many of the participants, including myself, are contesting our position, not appealing to another.

I have thus far focussed on the ethic of destabilization through multiple identifications which Newman (2016) contends defines post-anarchist practice. The focus on the narrative is insightful for destabilizing or affirming psychiatric labeling. However, there remains something to be said about the possible political efficacy of this sort of gesture which calls attention to an aspect of post-anarchist thought that is sorely lacking: the distinction between style and narrative. I am forced to question the stylistic effects of the narrative operation of destabilization and the possible efficacy of a politics of this style. I have insisted that, consistent with the tenants of the ethics of post-anarchism, the messy, nuanced, and interlocking narratives presented in this dissertation makes a politics of resistance difficult to formulate. There are endless impossible arguments to be had between two seemingly incompatible alternatives: that of the psychiatrists' diagnoses and standpoints and the felt experiences of the individual.

All that said, it still cannot be denied that the act of storying itself suggests a continued belief in the possibility of alternatives or genuine appraisal of what already exists. Consistent with a post-anarchist position, there is not an outright rejection of the psychiatric apparatus in these stories but a desire to subvert some of its manifestations through an act of destabilization. It is the narrativizable experience, brought on by confrontations with psychiatric power, that makes us seriously interrogate the power of psychiatric medicine.

### *Contributions*

I will now attempt to answer more practically some of the questions I posed in Chapter 1, especially those related to the issues of resistance and agency in the mental health system. The voices I heard and delusions I experienced guided me on a journey that could be viewed as agential or self-regulatory. I had no sense of control or knowledge of how this was the case, but the capacity I demonstrated was surreal and allowed me to interact with other-worldly dimensions that both spawned and helped me overcome nightmares. It was all a figment of my imagination but it was still a reality I engaged. The madness was simultaneously an act of breaking down and creation and one of impulse and autonomy. Madness took away my autonomy and also provided me with autonomy, where I fought constantly for a sense of control, and at times I acquired this, even it was only brief in duration. I resisted the traffic in my head and I also obeyed it. This is a complex definition of agency, as I have oscillated between treating autonomy like an object that is possessed (like Marx treated power), and also a web of relations, in the Foucauldian sense. At other times, the agencies being expressed seem to be something the user has access to and can manipulate to varying degrees. Psychosis thus brings about an agency that must endure a great lack of ontological security and stability, and one that is difficult to map.

When I was on my own and not getting anything from the mental health system, I was both battling psychosis and trying to use it to my advantage. Doug described a similar pendulum, swinging back and forth between the Zen and paranoid states of mind. Mental health agency thus must be conceptualized as a kind of directionless flow, where impulse, gravity, and the laws of the earth interact to create a complex stasis that plays on the imaginary. In a total state of madness, I still used reason, such as when I activated my GPS phone to find my way back home. While I could not see reality for what it was, I was not totally lost from it. I held on to a responsibility to preserve my own life. Madness therefore is not always a loss of reason but a different kind of interaction with it,

where one pulls back and forth between plains of consistency as well as escapes with lines of flight. Statements like telling my wife “I am alright” during madness signify both a tension and acceptance of madness. The mad identity in this sense is one that is not fixed, and certainly temporal, rather than a permanent label that comes with a finite definition. Even though mad people can become pulled into an absolute loss of autonomy, we also can get pulled back; often we can bring ourselves back to a level of thinking that is survivable. Without proper intervention, this is necessary to live under abject circumstances.

We learned in this dissertation that resistance to delusions and the psy complex can be both overt and subtle. I fought against unreality, which in turn constituted a kind of secondary reality. Take for instance, my preparing for war against the people I thought were trying to kill me. It gave me a sense of control that day; something to fight for, some sense of protection against the internal warfare, and some sense of safety. Mad people’s capacity to resist cannot therefore be intellectually discarded or suppressed but must be looked at for its imaginative potential, especially when little intervention takes place. And such resistance can help to keep the world in view; even if we no longer are of it, we can become aware of it. As Doug mentions, “I still felt that I was in control...even though I wasn’t all there”. And that awareness signals a kind of capacity to keep moving on in the adventure, to get back to real life. In Jermaine’s case, even rolling cigarette butts and finding something to do with the day kept pressuring him to move forward, to keep seeking help even when there was not any.

My interactions with mental health professionals during my acute period of suffering were numerous and, often times, trivial. How is it I could be experiencing something so terrible and drastic and desperate, but appear to so many as ‘sane’ enough? What kinds of accountability are there to professionals who, in the face of evidence of madness, ignore these cries? I was overtly

delusional, and Jermaine was in dire need of medication to ease his psychosis, and a social worker to help get him back on his feet. There was no accountability to these doctors, who in their power, are in complete control of who gets labeled as sickly ‘enough’ for intervention, and who does not. And several of these people turned us away, despite all circumstances pointing to the obvious. In a state of acute madness, especially when the people suffering are disadvantaged, who is liable for their care? I had to rely on my own agency and the care of my family just to survive long enough to get treatment, even when I played games with the doctors and refused their labels, it was not viewed as a red flag. Jermaine likewise had to count on himself to continue fighting for recognition in the mental health system and wait for his psychosis to die down enough to eventually come to a position where he could start helping himself. These findings recognize that in the face of mental health struggles, the psy industry can choose to respect the autonomy of the service user by not labelling us as sickly ‘enough’, which carries very big tensions and risks.

This dissertation likewise reveals a capacity for service users to resist the psychiatric apparatus while still maintaining the mentally ill identity. Not all of psychiatry, it seems, has to be rejected, but our micro insurrections reveal areas of entanglement and disarray that could shift power relations in a way that could provide service users with more autonomy and self-determination. Doug’s resistance of hospital governmentality was passive and non-violent. Psychiatric resistance and navigation allowed him to maintain a sense of identity during his madness, staking claim to the elements of it that provided him with enlightenment, perseverance, and joy. When the hospital medicated him forcibly, he lost this feeling of euphoria, but other negative side effects also disappeared with the medication. The authority of the psychiatry ward interrupted madness and took all that madness has to offer away, but passive resistance to its techniques demonstrates the

awareness of Doug to still play with elements of his identity even if his measures did not suppress the force used on him.

When pressured by ward rules and regulations, this study finds that resistance will take its rightful place alongside power. The mitigation of power, I believe, would mitigate resistance and produce more fruitful and mutually beneficial relations between doctors and service users. Psychiatry has to decide what is infantilizing and what is necessary to maintain order in clinic atmospheres that contain all of the mad people in one area. We also have to consider how to debunk stigma. Doug resists the stigma of being Bipolar. He does not carry the negativity that emerged as a result of illness with him, and responsabilizes people to move on from his past because that is what he has done. Again, we see here a post-madness agency of reflection and commitment not to be torn down by the negativity that surrounds serious mental distress. But this state of mind is not something all of us can live up to and it is the duty of those reading this to invite service users into a world that is more open minded to hear these stories and determine what is useful in them to improve upon their reactions to madness as well as those of the mental health system.

There is much to be said about how the service users in this dissertation engage their mental health identities. Most seemed to accept that, in some sense, they were ill and that their illness constituted some of the descriptions articulated in the DSM. Zach and Doug, for instance, needed the label of Bipolar to help them come to terms with some of their past sufferings and abuses. The label helped shift responsibility from the self to something more external. But alongside this acceptance, we saw other participants try to shake some aspects of the psychiatric identity, carefully negotiating its tenants into a workable fixture that allows room for growth and resistance. While Hannah knew she had an Eating Disorder and struggles with depression, she had the agency in this state to disengage from medication use – a decision he made without her caregivers' approval. Zach, too,

carefully played with his dosages to work out a method to achieve better in school, but the pill also silenced his will to resist; there was a mutual exchange of bending and conforming that a medicated body instilled. Aisha understood that she had deep issues with mental health, and used creative outputs to muster up the courage to seek help beyond the self. Edgar similarly used creative methods for escape, and to develop alternate realities that are more livable than the realist world.

According to these findings, the mental health label is just the start of the what seems to be a very complex relationality with psychiatric diagnoses, and one that works together to achieve a sense of self that acknowledges sickness but leaves room for resistance. Service users respond to their mental health labels with wonder, puzzlement, conformity, and conflict. How these identities are caught up in racialized, gendered, classed, ableist, and aged markers of inequality needs further examination in future research. Furthermore, more research is needed that takes into consideration the voices of family members and caregivers who are caught up in the vortex of “care”. I must also acknowledge that the participants were drawn from a small pool that represents a narrow understanding of first-person accounts and that what is written here may be taken as contestable by others with first-person experience (see Bassman, 2007; Burstow & Weitz, 1988; Pembroke, 2009; Romme et al., 2009; Russo & Sweeney, 2016; Shannonhouse, 2003). Many mad people feel they are held hostage by psychiatry and forced to frame their experiences as illness even if that does not fit their understandings. Biomedical explanations are often experienced by people as violent, sanist, and reproducing the very stigma that is experienced by so many who are caught up in psychiatric diagnoses and treatment. Of course, it is impossible to uncover all the meanings of madness and cover the full spectrum of meanings in one project. My postdoctoral project on Home Treatment Programs will assess the family impacts and dynamics further, and examine how, if at all, we can exact a threshold when service users can no longer make decisions about their health. I plan on

formulating a research design that integrates the perspectives of caregivers, family members, and mental health service users, and continue to explore what it means to be mad by many other people. This dissertation was just the start of this important work.

Allow me to now assess our narratives to determine how they speak to broader needs and strengths in the mental health system.

### *Practical Assessment and Recommendations*

I experienced a psychotic episode that was far on the spectrum of surreal. I heard voices, saw things that were not real to others, was paranoid of everyone and everything around me, and somehow in this state, I survived and did not physically hurt anyone around me – which many people in the public are fearful of in general. At least initially, the mental health system could not properly diagnose my condition nor suggest an intervention that could adequately heal me. I heard many different explanations: stress, thyroid problems, and Bipolarity, none of which were ever confirmed by the psychiatrist who successfully treated me. I escaped hospitalization many times, as the state going on in my mind was not clear enough for professionals to see me as posing a danger to myself or others. It was hidden, even though I was battling suicidal ideation and urges to harm others who I thought were malevolent. I lived on in a stasis of total madness for many months, searching for epiphanic answers to spiritual questions, and fighting chaotic and dark forces that wanted me dead. I was hell to be around, but still had family who kept on searching for solutions to my problem. In this respect, family took on the role of the healthcare professional (LeCloux et al., 2016, 2017; Pernice-Duca, 2010), and had they not been there, I may not have survived the ordeal.

When I found help, my psychiatrist wondered how it was possible that I flew across the country in such an apprehensive state of mind. He also made it clear to my mother that the way I was treated by the mental health system on the west coast bordered on negligence. I should have been hospitalized, and given more medication than 1mg of risperidone, which he equated as giving me an Advil. The deficit was that the mental health system and its many doctors failed to identify and respond to my symptoms of madness, despite urges from my wife that something was terribly wrong. Incidentally, this occurred during my second psychotic break as well. While I still had the capacity to tell doctors I was experiencing paranoia and voice-hearing, they suggested that they were not hearing psychosis, likely because I still projected a sense of control, which they were not used to seeing. The agency I possess in being able to talk about psychosis while being psychotic created confusion, and it was not until I dug up my psychiatrist letters and took them to the emergency department that they began to assess me seriously, give me adequate medication, and make a referral to have me assessed continually.

For people in my circumstance, as was the case with Jermaine, our agency and resiliency helped us to survive abject conditions and keep pressing forward, waiting for something to get better. Even during my first recovery, the drugs I was taking took a long time to bring me back to a safer, more trusted reality – one that I had to reflect on for a long time, going through this process of sifting through what I took to be real or unreal in my delusions. The implication of my story seems to be that anyone experiencing psychotic symptoms should be taken with the utmost seriousness, not denied medication, and observed continuously at least in an outpatient setting until the symptoms discontinue, especially if the service user wants this or cannot communicate it.

It is clear that not all doctors (and even psychiatrists) understand serious mental illness to the extent that they can always identify its onset (Hovington et al., 2012); the poetic and artistic way I depicted my struggle shows how complex the experience is. Even now, I struggle to find words to capture its ineffability. Prince Edward Island recently opened several new mental health walk-in clinics that are solely dedicated to identifying and treating mental health emergencies and disorders (Health PEI, 2019). Perhaps having more of these spaces funded and open across the country would ensure that some of the burden is displaced from the mental health system; a burden that causes them to make mistakes and prioritize other aspects of case management over treatment. Then, the mental health system could start living up to its own standards.

Jermaine's story further emphasizes the need for social workers to be staffed at these facilities. I know from my previous work experience at an Ottawa hospital that social workers were present during the week and daytime hours, but not present overnight or on weekends. Had Jermaine had access to a social worker, then the socio-economic issues his psychiatrist identified as causing his problems *might have* been better addressed (Regehr & Glancy, 2010), rather than sending him back on the streets exhausted, psychotic, and intoxicated.

As I mentioned briefly, the labelling of mental illness went one of two ways: either the service users accepted their pathology and used it as a comfort to help explain the adverse events and ordeals in their life, or they expressed discomfort with the label, unsure if their doctors fully understood and recognized the complexities of their mental health struggle. Both Doug and Zach encountered relief from hearing the label because it offered them some explanation as to why their lives had turned out the way they did, and why they could not

live up to the academic standards they or their families imposed on them. Clara was never diagnosed formally with a mental illness, but was told that she had some markers of Post-traumatic Stress Disorder. Her psychologist, while not seeing enough symptoms to mark her as mentally ill, still worked through her problems and helped relieve her anxiety. Heather, in contrast, was never satisfied with the label of Depression and Anxiety, as she felt the doctors emphasized her Depressive symptoms more than her Anxiety, which she believed was the cause of her Depression. If they just focused on her Anxiety, she believed that the other symptoms would in turn go away. Of course, she accepted medical power enough to just do what her psychiatrist told her, even though she did not fully believe in it, and the treatment was not fully working. When I was told by my psychiatrist after my second psychotic break that I had Schizophreniform Disorder, it hit me like a ton of bricks. I felt stigmatized, unwell, and out of control of my destiny. But I told my doctor these feelings, and she reminded me of all the successes I have achieved in spite of the label, and how my prognosis is actually very good because of the amount of awareness I have, and how I still have a strong ability to work. This satisfied me enough to not let the label become my identity, but just a diagnostic category I need in order to be able to access the mental health system when I need to, and receive the appropriate treatment.

These accounts reveal the complexity involved in making determinations about what constitutes a mental disorder, and what problems or epiphanies are encountered when a label is thrown down on the disorder with surety. The DSM is indeed a “boss text” (Burstow, 2016); when it is activated it carries a strong current of power. Sometimes the reality it offers is welcomed by service users (Rose, 2005), but other times it can be abused or misused (Tosh & Golightley, 2016). This research demonstrates the need to think carefully about activating

mental health labels. Medical professionals must understand that when they use these diagnostic tools, they should be open-minded to the possibility that these labels might change, and should be willing to negotiate with service users their applicability. This is a difficult suggestion to bear in mind since doctors may want to show their patients a sense of control and authority they have over their diagnoses, but in doing so, they run the risk of infantilizing the user to the extent that they are seen as unknowing of their own conditions – conditions that they, after all, are the ones experiencing. On the flip side, those critical of the psychiatric apparatus must accept the good work that some doctors are doing in giving meaning to those who experience mental illness.

Doug was the only person in this dissertation who overtly resisted the psy apparatus. He drew on passive techniques of resistance during his hospitalization so as to not submit to the authorities of his doctors who wanted to control him through food, and who were startled at his attempt to go on hunger strike. In Zach's case, he took control of his medication doses by playing with the amounts he would take in order to achieve the highest amount of academic success. When he encountered medical professionals he could not trust or he framed as racist, his solution was to disengage them and find someone else who could better understand his cultural identity and issues that were causing his distress. So what space is there forfeited to service users to resist aspects of their treatment and encounters that they feel are insufficient or making matters worse? The simple solution for Doug might have been to better negotiate with him, rather than pin him down to a bed, expose his buttocks, and inject him with 'medication'. Why could they not have just found him the appropriate food to eat? One would think that any hospital would have raw vegetables lying around, and a container of juice.

Communication styles and interventions on psychiatric wards should be open to concession to avoid having to resort to displays of power and social control in order to get a patient to submit to protocol. I have argued elsewhere that these measures of restraint and sedation should only be used as a last resort (Johnston & Kilty, 2014), and given that Doug was never violent, it was overkill to subject him to such an intervention, even though he framed it as not being the worst experience of his life. Perhaps more importantly, what was absent following his restraint was any kind of debriefing exercise that could have built his trust back up in the doctors and nurses to care for him (Khatib et al., 2018) — people he admits need to be present in our society to deal with most mental health related issues.

With respect to Zach, his issues with psychiatry had to do more with the power imbalances present during his sessions. Heather echoed a similar circumstance when she mentioned how she did not feel able to communicate in an authoritative setting his issues with her psychiatric diagnosis. It might seem simple, but active listening skills in medical settings would go a long way at ensuring proper diagnose, and also might flag some possible medical errors in judgement that are being made in the overburdened mental health system because of the (often) short nature of the encounters (see Mjøsund, 2018). Patients who disengage from their doctors should also be given the opportunity to debrief, or perhaps complete a brief exit survey, so that clinicians can learn from these cases, and if necessary, alter their approach so that more patients are willing to engage treatment. Clinical settings must also make room for spiritual definitions of madness, and allow some of the enlightenments that are learned through serious mental illness to not always be pathologized and discounted from care (Tenney, 2016).

Burstow (2018) stresses the importance of raising our children in caring rather than corrective environments in order to prevent mental illness later in life. The finding that child abuse, bullying, and unwarranted pressure leads to more mental health concerns is echoed in the psychiatric literature (Chang et al., 2013; Rezaei Ghalechi & Kazemi, 2013), and also in the narratives found in Chapters 7 and 8. We witnessed intense struggles of children and adolescents trying to live up to their parent's conceptions of achievement – achievements that some people take a lifetime to accomplish. We also saw how childhood and adolescent bullying can leave deep scars on the mind, but also propel these mental health service users to use those experiences to help others. It is amazing how Daniel started a community initiative to target those forgotten in our society such as homeless people. Edgar uses his art and storytelling to share with others how he overcame domestic violence. This study demonstrates that we need to continue to address bullying in the workplace and school settings, and if we have children, be cautious about how much we pressure them to succeed in early childhood. We must also give mental health service users a seat at the table when making policy decisions, as their ideas are both creative and endless.

### *Final Reflections*

For a number of reasons, this research was extremely difficult to do. First, it was triggering. Some may wonder how I was able to recreate with words and sounds my experiences. I had to experiment to find ways to recount the horrors of my minds – traumas I would not wish upon my worst enemy. I listened to dark music, prayed endlessly, and accessed a form of meditation where I would actually relive some of the pains. I would not recommend this technique to service users. But I needed to tell my story, and I needed to listen to others. I needed to figure out exactly what happened to me, and what went horribly

wrong. I needed to make right and do justice to my experience. And as my family reads this, I need them to know how much I struggled to stay alive, for their sake, as I met the doors of Death. I need them to know how much I deeply appreciate their struggle to keep me alive, and to repair our relationships, so that these words and stories will live on forever.

Second, going public with my mental health challenges is not easy. The world is a stigmatizing place. Some people may read this and dismiss me as crazy. They might become afraid of me, or afraid of what I could do. They might discount all that I experienced as a delusion. They may be weary to accept any critique of the mental health system, because of how ingrained psychiatric power is in the collective consciousness. There is a lot I risk in coming forward as a mad person who just entered the job market. But all these factors will not suppress my truth. It has been boiling up inside me for too many years to not let go of. The act of writing this dissertation is a miracle. Because the chains that held me from being who I am really am are now released into the depths of the world. I have been enlightened, I have seen God, I have made sense of the non-sensical, and I can move forward now. I am a better man because of this research and experience. I am at peace, even though I may still suffer. But the darkness will never destroy my dreams because I have faith in love. Love “always protects, always trusts, always hopes, always perseveres” (1 Corinthians 13: 7). I know love now, because love saved me.

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