The Foucauldian Madwoman: Four Weeks in the Psychiatric Facility

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Abstract: This article is simultaneously a personal narrative and a Foucauldian analysis of the author's embodied reality as a racialized woman hospitalized in a Western psychiatric facility. The author is the narrator, the mental patient (main character of the story) and the person who deconstructs the experience (researcher, insider). This unique position – a South-Asian patient and a researcher/scholar trained in a Western academic institute – provides her an opportunity to give voice to her direct experiences in the psychiatric facility, as well as describe her reality of mental illness. Such rare, self-reflective 'insider' perspectives challenge the Euro-centric conceptualizations of 'mental health' and may be unsettling to the psychiatry/psychotherapy and/or academic communities. As our population becomes more diverse, mental health professionals and policy makers will need this knowledge to broaden their understanding of how members of diverse cultures may experience mental health, as well as to support them in their cultural ways of self-healing. Social science research methodologies that do not further reinforce the binary – us/them, expert/client – offer a holistic understanding of clients' mental health and are necessary to develop effective psychotherapeutic interventions.

Keywords: mental health; psychiatry; immigrant; euro-centric; culture; ethnography; binary; Foucault

This article is a personal narrative of my experiences as a patient in a psychiatric facility in Canada in the 1990s. Such forms of story-telling, unlike traditional normative genres, permit researchers to link the private with the social/professional, the personal with the political, and the Self with the Other (Ronai, 1995; Ellis, 1993; Richardson, 1990). These genres open up spaces in the academy for cultural narratives of marginalized individuals and tabooed topics (Ronai, 1995; Vickers, 2002). Like Ellis (1993), in this project, I use my*self* as a case study and as a subject, and my experiences as primary data, a method that Jackson (1989) referred to as "radical empiricism" (cited in Ellis, 1993, p. 725). I am the narrator (the author), the mental patient (main character of the story), and the person who deconstructs the experience (researcher, insider). This unique position – a South-Asian patient and a researcher/scholar trained in a western academic institute – provides me with an opportunity to give voice to my direct experiences in the psychiatric facility, as well as describe my reality of mental illness. In the evolving Canadian mosaic, such critical, self-reflective 'insider' perspectives in scholarly writing have important implications for health-care with immigrant and refugee populations. First, such first person accounts have the potential to contextualize the everyday lives of immigrant women living with a disability. Second, such discourses narrow the gap between the social worker/mental health scholar who is an 'outsider' and the one who is an 'insider' (Lee, McGrath, Moffat, & George, 2002). My primary goals for this article are to problematize the Eurocentric mental health discourse and to build upon literature that argues for alternate writing formats to conventional methods. At the same time, it is a call to other scholars to write, live, and perform his/her vulnerable/tabooed identity.

The writing of the subsequent section unfolds in several parts. I commence with *Four Weeks in the Psychiatric Facility* where I narrate my experiences of institutionalization. In the next section, *Telling Stories: Writing on the Razor's Edge*, I address the power of narratives. This is followed by *The Foucauldian Madwoman*, where I problematize my experiences within the psychiatric facility vis-à-vis the Eurocentric bio-medical model of mental health. I conclude with *Looking Ahead: Implications for Social Work Practice*. Here, I examine scholarship on current psychiatric practices and how it can contribute to social services delivery to the immigrant population.

Four Weeks in the Psychiatric Facility

It was a beautiful spring morning. I watched the birth of a new dawn as I snuggled close to my dog, Duke, and with my cat, Lucky, lazily stretched at

my feet. My soul was restless. Like the troubled sea, it had wandered far away to a place I called home. All night, I was haunted with the memories of the past. It would be seven years this Christmas, I thought, since I saw my mother. The silence of the distant recollections was brutally invaded by the sharp ring of the phone. My heart beat violently. A feeling of dread welled up from the tips of my fingers and gripped my whole being as I whispered, "Hello," squeezing the bed-coverings close to my chest. After a moving silence, I heard my brother's voice: "Mom died last night. She was visiting me in the Sultanate of Oman. The funeral is in two days. I am sorry that there isn't enough time for you to come here." As the day slowly turned to dusk, I felt my strength abandon me to my grief. "Be silent, my heart! Be silent," I moaned as I gathered the last remnant of my strength and called the crisis line. The psychiatric nurse advised me to go to the emergency room so that a doctor could give me some medication to help me get through the weekend.

In the emergency room, I wrapped my arms around myself and waited for what seemed like an eternity with the phantoms of the night. "Be silent, my heart! Soon, it will be dawn," I repeated in a hypnotic trance. I was deeply engrossed in my thoughts of childhood with my mother when, uninvited, the stinging arms of dread grabbed my suffering soul and pierced my heart. My weeping stirred the silences of the night, my trembling shook the floor. In desperation, my soul pleaded, "Just give me something to sleep. My mother just died." Strange arms held me down. "Are you suicidal?" "Get a stretcher." Strange arms seized me. "Ma'am, lie down. Relax." My spirit rebelled, "Let me go." They found my chart. "She has been here before. She is diagnosed with Post Traumatic Stress Disorder (PTSD). No family here. Call her friend…" Strange voices spoke over my body, around my body, *about me*. A haunting feeling welled up inside me. I tried to speak, my tears expressing my grief: "Let me go," my voice faltering in the chaos of thought and confusion. My eyes became glazed. Ghostlike figures performed their act before me. Venom rushed through the IV into my brain. Paradoxically, it was a moment of terror and relief, punishment and reward. Under duress, my will to fight succumbed to the magic of the sedative as the stern face of the nurse vanished into the abyss. I gazed into nothingness until next morning…

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As dawn flooded my room, I opened my eyes to the distant sound of emergency sirens, the monitor beeping, doors opening and closing, hushed voices, and eyes glaring at me from behind a face plastered with a smile. The man in a white coat checked my pulse while the woman in navy blue scrubs fidgeted with my chart. Sombrely dictating his instructions to the woman, he strolled out of the room, the nurse close on his heels. During that encounter, our eyes never met. He did not ask my name. I lay in bed watching their shadows leave my room, their footprints leaving no trail behind. Images of the previous day passed through my mind.

The phone call. Yes! The phone call from my brother. The news of my mother's demise had sent shock waves through my body. Hyperventilating, I had rushed to the emergency room. Wait a minute. With trembling hands, I had first called the crisis line. It was the psychiatric nurse who had urged me to go to the emergency room. I remembered sitting for hours on a cold metal chair, straining my ears to hear my name over the speaker. The shrill voice of the receptionist, seated behind a Plexiglas barrier that separated my body from hers, intermittently pierced through the sound of the vending machine, ambulance sirens, rushed feet, and crying children: "Mr. *Smith*... Mrs. Carnegie *to the counter."* The smell of disinfectant penetrating my nostrils made me nauseous. Oh! How alone I felt amongst a crowd of men, women, and children waiting. With each passing moment, my panic increased. Images of my grandmother mourning, my mother mourning, my sister mourning, and my aunts mourning began to explode in my mind … I tried desperately to dissociate my *self* from those images. I paced up and down the hall. It annoyed the staff. My spirit was in turmoil. I longed to be with my mother for the *Antim Sanskar.* I ached to kiss her good-bye on this revered day of her cremation. Questions bombarded my mind: Was she afraid? In her final moments, did she know that my heart prayed for her peaceful transition from the stage of *preta* to the realm of *pitrs*? Her soul **must not** linger in the earthly realm as a *ghost*. It must transition to the land of our ancestors. I moaned from the pit of my being: *Ma! Ma! Ma!* I howled like a lioness that

had just lost her cub. Without warning, my ancestors' spirits encircled me, chanting hymns and mantras. Kneeling on the floor, I joined them. Haunting memories of past funeral ceremonies overpowered my senses. I began repeatedly beating the sides of my head with my hands in almost complete synchrony. I became my grandmother, my mother, my sister, my aunt… Trance-like, I continued the ritual of grieving so typical of South-Asian women. Dropping my head to my bosom, I wailed and cried. Someone tried to help me to my feet. "Are you suicidal?" I tried to raise myself on one elbow. My legs had forsaken me. Collapsing to the ground, I tried to hold on to the fading image of my mother. My ancestors became silent. White sheets. IV bags. Disposable gloves. Oxygen mask. Syringe. I woke up in the psychiatric unit. For the next four weeks I was branded *mental patient 11*. I lived under the surveillance of the psychiatrists, nurses, and social workers.

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I spent the first two days of my hospitalization in a state of mental sluggishness. For the most part of the day, I was *ordered* to stay in bed. Thereafter, every morning, the nurse would knock on my door at the break of dawn. By 8 a.m., I would be psychologically evaluated, asked questions such as, "How was your night?" Depending upon the psychiatrist's evaluation, I would either proceed to the common room for a *mandatory* group meeting with the rehabilitation social workers or be restrained in my room. As a result of my two outbursts, I was considered a 'high risk' and kept under heavy surveillance. All I wanted was to go to my apartment and call my brother. The nurse on duty informed me that this surveillance was *for my personal safety.*

On the third day of my hospitalization, rubbing the weariness from my eyes, I made my way to the common room. The smell of fresh paint and new furniture made me queasy. I wondered if the real problem was my medications: *Trazadone, Serzone,* and *Serax*. My body, primarily treated with Homeopathy or Ayurveda (Hindu traditional medicine), was not familiar with these anti-depressants and anti-anxiety pills. A voice at the nurses' station directed me towards her. The gossip stopped momentarily as one of the staff gave me a *Rivotril* pill that I was ordered to take three times a day. I protested. My voice faltered. My justification failed. No sooner did I return the empty paper cup and plastic glass than the nurses resumed their gossip, their backs towards me. In the living room, I was greeted by dazzled eyes, shrivelled hair, lucid movements, incoherent speech, and tragically solemn bodies. These were the faces of madness. I was now amongst them. An hour passed. Bored, I stared at the wall calendar, the dates making no sense of time. A social worker tapped my shoulder, "Here is your schedule for the upcoming weeks."

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After the roll call, we would be broken down into smaller groups of four patients headed by a social worker. Being part of the group that was under 'heavy surveillance,' I was cautioned to stay close to the staff member and to let him know if I needed to go to the ladies room. Depending on our schedule for the day, we would then head down to either the activity room, the pool, or the crafts room. Ironically, I both loved and hated the long walks through the corridors. I loved them because it provided me with an opportunity to leave the psychiatric ward. Once the activities were completed, I was trapped inside, unless a friend was kind enough to take upon herself the responsibility to take me for a decent coffee or a short stroll and safely return my body back to the nurse's station. I longed for the sun on my face, the kisses of my dog, and the soft purr of my cat. I hated these walks largely due to my close encounters with the 'sane.' I was differentiated from the sane by my green hospital shirt and a wrist band. I could feel their piercing eyes penetrating my branded skin as I tried desperately to hide the band on my wrist – a reliable signifier for the sane that their space was being infiltrated by us, the mad men and women. I/we represented a threat to them. As I/we walked down the halls, I would witness their bodies shrinking against the wall. They made space for us so that our branded bodies would not touch their skin. Their antipathy poured out of their mouths and they tried to cover it with their palms. Mothers would grab the hand of their child and almost run as they saw us coming down the hall. Sometimes, they would point to us in deep fascination.

At sunset, finally left to my solitude, I would vividly recall that hot day in the crowded Mumbai airport.

That was seven years ago when I departed from India to Canada. What if I had known then, I wondered, that it would be my final farewell to her? I would picture my mother's *Antim Sanskar* against the backdrop of the white hospital ceiling. She must have looked like a *suhagan*, a newly wedded bride, dressed in a red *saree* and a large red *bindi* covering her forehead. That *bindi* gave her a sense of dignity. I would run my hands over her face. I wondered if the priest had blessed her with the holy Ganges water in her final hours. Not knowing caused my heart to beat violently. Even though I do not subscribe to the Hindu beliefs of auspiciousness and inauspiciousness and believed without a doubt that she deserved a much better husband than my father, I took comfort in knowing that my mother's wish to die a *suhagaan* was fulfilled. From my hospital bed, I travelled with her to the *Shmashana ghat*. Gloomily, I pictured her body on the funeral pyre and my brother with a flaming torch in his hand. For my sanity, I had to trust that the god *Agni* embraced *Ma* in his fiery arms, thus liberating her from the earthly realm. The shuffling of feet would ungracefully interrupt my thoughts. Before I could brush my tears away, a hand, barely touching me, would thrust the paper cup and plastic glass in front of my face. A few deep inhalations and I would drift off into a drug-induced hypnotic state. After being restrained to the bed for the second time within a week, I abruptly brought my prayers and grieving to a standstill.

Wasn't it ironic that after seven years in Canada I had finally attained my freedom from immigration bureaucracy only to be locked in a psychiatric facility? Every cell in my body wanted to resist the biomedical western psychiatry. Nevertheless, I crumbled. I started attending morning and evening 'roll calls,' showing great enthusiasm for daily activities, even becoming a member of the nurses' gossip group. At last, the psychiatrist, beaming, informed me that I was no longer under heavy surveillance. The nurses and social workers applauded. Four weeks later I was given a certificate of mental health.

Telling Stories: Writing on the Razor's Edge

Writing is and has been *sacred* to me. As my emotions take shape in the form of alphabets, commas, dashes, bold letters, italics, and so on, a load begins to lift from my heart. As I write, erase, and edit for clarity, purity, and coherence, I realize that my writing is already tainted by my hand; it can never be "pure," "objective," and "innocent" (Richardson, 2001, p. 34). Like a razor sharp knife, writing cuts through my heart and slices my emotions to manageable bits. As my pain and suffering bleed on paper, writing empowers me. It gives me strength to open my curtains and let sunlight into my room day after day, especially in times of danger and terror. This is how I survived the trauma of childhood abuse. During my teens in the Middle East, I wrote in order to travel beyond the walls of my physical imprisonment. Throughout my early adulthood in Canada, I wrote to stand firm against the terror of immigration. Today, as a social worker and scholar, I write as a form of *resistance, empowerment, and a tool of social and political action*. Such forms of ethnographic creative expressions, unlike traditional genres, provide room for expression of emotions (Richardson, 2001; Ronai, 1995).

Undeniably, objective reality, pragmatism, and statistics have their place in the academy. I am not suggesting that "an account of lived experience should be privileged over other accounts" (Ronai, 1995, p. 398). Like Richardson (2001), I do not desire "to position my work as 'counter' to traditional scientific writing formats but rather write through the 'personal' binaries (me/them, good/bad, for/against)" (p. 36). I do not want to contribute further to the binary obsession – subjective/objective, client/expert, and sane/insane – that the academy promotes (Ellis, 1993; Richardson, 2001; Ronai, 1995; Vickers, 2002). Ethnographic writings and other arts-based paradigms are compatible with my cultural tradition of passing knowledge to the next generation through oral stories. Creative writing offers me, a novice researcher-student, salvation – not in the religious sense, but in the sense of freedom from the stringency of academic writing. Such evocative writing practices allow me to speak from the depth of my being, to connect my head with my heart, and in the process attempt to bridge my objective-subjective and public-private selves (Ronai, 1995; Richardson, 2001). Yes! I am cognizant of the risk of sharing stigmatized information about myself, as my work may not be taken seriously (Ronai, 1995). I could be labelled sick and self-indulgent (Vickers, 2002). Ronai's (1995) *Multiple Reflections of Child*

Sexual Abuse – a retrospective account of the author's experience of childhood sexual abuse – is a good example of risk taking in academy. Listen to Ronai (1995) as she echoes the 'risk' of writing self in the text:

> The real horror may be that we love sociology even when it abuses us by demanding that we repress our feelings when writing about research. Ultimately, a critical perspective is necessary to understand that information, through oppressive social science formats or suppressed accounts of child sex abuse, is not being disseminated because of spoken and unspoken rules about acceptable topics and communication strategies. Both silences must be abolished as harmful and legitimate. (p. 423)

A basic critique of the standardization of writing formats in the academy is that it suppresses the creativity of researchers by privileging the rational, all-knowing voice of science and scholarship (Ellis, 1993; Ronai, 1995; Richardson, 2001). Denzin, Lincoln, & Giardina (2006), for instance, problematize the philosophical and epistemological issues of what counts as 'good science.' Fighting for freedom of speech and democracy in the academy, these authors support scholarship (narratives, stories, and performances) that is "committed to social justice and the promise of radical, progressive democracy" (p. 769). Borrowing from *The Sydney Writer's Festival*, Vickers (2002) questions why the academy accepts research participants' stories as 'knowledge' while discarding researchers' sharing of their life experiences as "cathartic, narcissistic and self-aggrandizing tendencies" (p. 617).

In recent times, medicine and nursing have witnessed a rise in autobiographical accounts of illness (Wilks, 2005). Even though social workers are apt at the telling and retelling of service users' stories, it is only lately that the field of social work ethics is recognizing the potential of service users' narratives for practice intervention, as well as a framework for analysis (Wilks, 2005). My experiences – immigrant woman, social worker and scholar – drive my academic and community work. In telling my story, I hope to "situate my work in [a] socio-political, familial, and academic climate" (Richardson, 2001, p. 34). Fully conscious of the Western academy's resistance to researchers sharing their life experiences and its judgement of 'good/bad scholarship,' I place my multiple selves on the razor's edge. I run the risk of being sliced to pieces through sharp criticism from other scholars. I take courage from Carolyn Ellis, Carol Ronai, Laurel Richardson, and others who have been instrumental in problematizing their intense personal experiences to bring to light systems of oppression and generate powerful insights in their respective areas of study. Their writings have illuminated how people are active agents in meaning making. In the interest of supporting diverse ways of knowing and resisting "Western sensibilities and rationality on experience" (Denzin, Lincoln & Giardina, 2006, p. 774), I prefer to bleed rather than choose safety through silence or compliance.

The Foucauldian Madwoman

My narrative, like other narratives, reflects multiple realities and is open to multiple reflections, meanings, and interpretations (Richardson, 1990; Ronai, 1995). My story is uniquely embedded within a historically, economically, and politically specific mental health culture. As I write the succeeding sections I draw on Foucault's (1965; 1972; 1995) discussions on: discourse, madness, power/knowledge, surveillance, and discipline as the backdrop for my analysis. I am not attempting to evaluate, summarize, or critique his intense and complex work. Primarily, I am reaching out to him to answer certain questions that have continued to haunt me over the years: "*Why was I labelled 'mentally ill'?*", "*What were the rules that legitimatized my institutionalization?*", and "*Why was my cultural way of mourning pathologized and disciplined?*"

Foucault (1972) does not limit the meaning of discourse to a relationship between statements. Rather, he examines how historically situated social practices or structures of power/knowledge contribute to the production of subjects and their worlds, to the objects of our knowledge, as well as to our idea about reality. By situating power as the "other face of knowledge," he is able to make visible the association between power and subjectivity (Holstein & Gubrium, 2005, p. 491).

Foucault's discourse on madness implies that madness or madman did not exist as a solid entity prior to us naming it as such (Chambon, 1999). Stated in another way, something called 'madness' is constituted within the discourse. That is, madness or the madman is the product of that discourse that legitimates it as truth. For instance, in *Madness and Civilization*, Foucault (1965) reveals how throughout history the interplay of rules (political, economic, and religious), institutional practices, and public opinions shaped the discourse on madness. He asserts that it is a mistake to assume that the face of the madman that emerges from one historical period to the next – as the leper (Middle Ages), the fool (Renaissance period), the beast (Classical age), and the mentally ill (Modernity) – is one and the same – a single and stable entity. The central point, then, is that the idea of *madness* is a social and cultural construct. The knowledge and experience of madness depends upon a particular society's power structures and value systems. Undeniably, there can be no power without the regime of truth (discourse) that legitimates it (Foucault, 1972; Foote & Frank, 1999). Psychiatry as a site of power, a social practice, and a body of knowledge recognized by the government, the law, and the public stipulates assessment protocols, treatment regimes, prescription drugs, and recovery models universally across all cultural groups. The discourse of western psychiatry with its sweeping generalization and claims on medical truth – neutral, apolitical, and autonomous – legitimizes what it considers as *reality,* as well as what is deemed sane or insane behaviour.

My story illustrates how validating medical (expert) knowing, while discounting cultural practices and beliefs of the patient, biomedical psychiatry **exerted power** over me. The phone call that announced my mother's demise led to a chain of events that I have described in this essay. As my particular act of grieving – a ritual of my culture – deviated from the western psychological construct of human 'normalcy,' such behaviour then was diagnosed as *deviant*, requiring *correction* through institutionalization. Medical professionals whom I encountered in the hospital – the emergency room staff, psychiatric nurse, psychiatrist, and the social worker – concluded that my visit had everything to do with my psychiatric label and nothing to do with my grieving. The manual about me – my hospital chart – dominated my confinement and the treatment(s) that followed. Strangely, my culture was never a salient feature during my hospitalization. It is in the act of first labeling me *at risk* and then hospitalizing me – construed as an intervention for my safety – that psychiatry both as "an effect of power and the means of perpetuating power" (Foote & Frank, 1999, p. 160) produced and sustained its commitment to truth. Ultimately, power operating through discourse confined me in the psychiatric facility. Here, discourse and cultural hegemony joined hands and dictated my treatment and recovery plan.

Painfully, my Eastern health practices weren't recognized as legitimate within the Eurocentric, biomedical-focused approaches to patient care and healing. I ached for solitude, prayer, and meditation. It was through *labour* (mandatory rehabilitative activities), not *idleness*, that the psychiatrist expected to *normalize* me. This focus on productive work is not new. During a moment of epistemological shift that Foucault (1965) calls 'The Great Confinement,' disobedience by resistance to work was considered a major transgression against the bourgeois society. The madman, along with anyone who did not model a 'good bourgeois citizen,' that is, who engaged in idleness or who could not find productive employment, was shamed through institutionalization. In Foucault's (1995) account, discipline as a type of power comprising "a whole set of instruments, techniques, procedures, levels of application, targets..." has been historically used to control people according to the binary branding of mad/sane, dangerous/harmless, and normal/abnormal (p. 215). The staff at the psychiatric facility exercised disciplinary techniques of *Silence, Surveillance and Judgement* (Foucault, 1965; 1995) – age-old weapons to return the madman to bourgeois normality – to bring me back from the world of madness to the world of sanity.

Discipline: Silence, Surveillance, and Judgement

In the early days of my hospitalization, I resisted the rules, the practices, the psychiatric power, and any attempts of therapeutic fixing by refusing to eat or follow the institutional daily regimes. I was restrained. I was excluded. I was subjected to silent treatment. I was silenced. These actions epitomize what Foucault calls the 'truth games.' Foote and Frank (1999) explain that, for Foucault, truth games

are relational as both parties (observer and observed, therapist and client, doctor and patient) are seeking some form of truth. Within these truth games, these parties enact the intimate dance of power/resistance, silence/speech, and absence/presence. Evidently, power and resistance co-exist. In domination, however, there is no room for resistance (Foote & Frank, 1999). Whenever I resisted, my body was subjected to the violence of the conventional discourses of psychiatric staff that "polices mourning," "contains and confines it," and "defines complicated mourning as pathological" (Foote & Frank, 1999, p. 170). My cultural story of grief was alien to the practitioners because "the dominant discourse has no narrative for such experiences or for such interpretations of experiences" (Foote & Frank, 1999, p. 178). The therapeutic sessions focused on keeping me – a social deviant – within the psychiatric definition of reality. It is my contention that had the mental health practitioners focused on *my* grieving rather than my PTSD diagnosis, it would have required them to travel to an unfamiliar place, to problematize their subject location, and even risk *not knowing*. Staying with the discomfort of not knowing rather than reacting to the expert need to *know-it-all* could have created a space where the social worker and I might have engaged in an authentic dialogue about my recovery.

Throughout my institutionalization, I was constantly under surveillance. I was *expected* to follow the psychiatrist's rules of morality: attend meetings, participate in rehabilitative activities, take my medications, and so on. Sure enough, there appeared to be a *partnership* between the psychiatrist and social workers (Morley, 2003). For example, my mental health grades were largely dependent upon my day to day performance. The social workers administered the grades for these behaviours. The psychiatrist evaluated the report card and encouraged me to 'do better' each day. My point is: I was evaluated against a norm of behaviour prescribed by the psychiatrist. Due to these unceasing observations and judgements, I unconsciously began to monitor my behaviour, comparing it with the performance of other patients. After about a couple of weeks of hospitalization, I noticed that I had begun to inspect the walls and ceilings of the bathroom for hidden cameras. I was haunted by the "faceless gaze" (Foucault, 1972, p. 214) of those in control of my behaviour. Foucault (1965) describes a similar tactic of observation, "recognition by mirror" (p. 262) that was used by the eighteenth century therapeutics to control and assess the madman. In the asylum, the madman was not displayed in a cage as a spectacle of public observation and pleasure like the Classical madman. Rather, he was assessed through internal self-observation. The staff in Pinel's asylum encouraged the madman to emulate those outside the asylum (the sane) and refrain from behaviour of individuals within his community of madmen. Since "awareness was now linked to shame of being identical to the other..." (Foucault, 1965, p. 265) the madman recognized himself, as in the mirror, as objectively mad. In other words, it is through merciless observation of himself that the madman is convinced of his madness, thus madness becomes a spectacle of itself (Foucault, 1965). Similarly, I *internalized* the disciplinary power within my private and public psyche. I lived in a state of continual unease, highly vigilant of the faceless gaze of the doctor.

Foote and Frank (1999) suggest: "The internalization-of-power argument posits that those being ruled either accept the demands of those in power as legitimate or fear that 'they' – those who have power – may be watching" (p. 161). Alas! I was *forced* to comply. It was critical to my release that I produced signs of progress, that is, exhibit a reduction of symptoms. Compliance equates freedom. Any departure from prescribed rules of *time* (lateness, absences), of *attitude (*lack of fervour), of behaviour (disobedience, resistance), and of the body (irregular gestures, lack of cleanliness) was judged harshly, which resulted in punishment (restraint, loss of privileges, petty humiliations, etc.; Foucault, 1995). I surrendered. In the "doctor-patient couple" (Foucault, 1965, p.275), I submitted my consciousness to the doctor.

Paradoxically, as I navigated the waters of psychiatry, I found the psychiatrist as "divine" and "satanic" (Foucault, 1965, p. 275). He supposedly possessed *mysterious knowledge* to release me from the ghosts of my insanity. He had the power to keep me institutionalised as long as he thought was warranted, as well as to sign my certificate of release. In this dual system of "gratification-punishment," my behaviour was judged on the

opposed values of good and bad and normal and abnormal (Foucault, 1995, p. 180). I was rewarded with privileges for good behaviour and punished for bad behaviour. At the heart of these disciplinary punishments was the motive to sustain the master narrative of the medical model so that its powers are transferred to the next generation of psychiatrists just as the doctor transferred the power to Freud.

Like Foucault's (1965) madman, I was the "Passenger par excellence: that is prisoner of the passage" on the *Ship of Fools*, a "liminal position – on the exterior of the interior and vice versa" (p. 11). I was the locus of psychiatric discourse that constructed me as "mentally ill," yet I continued to be an outsider standing on the sidelines and excluded from this discourse. Ironically, the weight of my recovery and liberation rested on my shoulders. I was both the object of knowledge and the target of intervention. Buried under the power-knowledge nexus, I experienced the psychiatrist as *a judge* who would ultimately give me the medical certificate of sanity, *a clergy* who expected morality from me, and a *father* who claimed to know the best recourse for my freedom from mental illness (Foucault, 1965). Oh! How right Foucault (1965) was. The present-day psychiatric practice is nothing more than "A moral tactic... preserved in the rites of asylum life, and overlaid by the myths of positivism" (p. 276). In my experience, the face of the modern day psychiatrist is that of an archetypical, patriarchal, and patronizing figure.

Looking Ahead: Implications for Practice and Policy

In the last decade, the shift from traditional European countries to non-European regions (India, China, and the Middle East) as the source of immigration, thereby increasing the visible minority population amongst newcomers, has been one of the most prominent demographic changes in Canada (Chui, Tran, & Maheux, 2007). Despite these changing demographics, the western discourse of health and recovery that assumes a universal psychology of individual mental health, empirically supported treatments, symptom reduction, and prescription drugs continues to dominate Canadian mental health policies and practices (Bhugra & Bhui, 2001; Jhangiani & Vadeboncoeur, 2010; Morley, 2003). Even though psychiatry and psychology have made efforts to move away from a *mental disorder* to a *mental health* paradigm, as Jhangiani & Vadeboncoeur (2010) note, "health care approaches that determine how mental health is defined and articulated as policy have failed to adopt a culturally responsive perspective" (p. 169). Since the birth of the Diagnostic and Statistical Manual (DSM) – considered a corpus of medical knowledge – psychiatrists and other practitioners of psychotherapeutic interventions have used it as a diagnostic tool to separate the normal from the pathological. The diagnosing and labeling of individuals as 'mentally ill' based on the Euro-centric and disease oriented models have implications for practice and policy within the evolving Canadian mosaic.

Scholarship suggests that mental health practitioners frequently regard their Western ideologies as superior to other worldviews, stereotype certain groups (for example, South-Asian women are viewed as 'poor' patients – incapable of following instructions), and generalize their past experiences with a particular cultural group to all the members of that population (Jhangiani & Vadeboncoeur, 2010; Wong & Tsang, 2004). Bhugra and Bhui's (2001) disturbing finding is an example of the hegemony of the western bio-medical principles in mental health service. People from ethnic minorities are more likely than the general population to be administered higher doses of psychotropic medication for a longer duration and to receive treatment compulsorily with no clear explanations, and are "frequently not offered counseling on the premise that such individuals are not psychologically sophisticated" (p. 240). As a Native American scholar and practitioner, Calabrese (2008) is well versed with the harmful consequences to his community's mental health as a result of the Indigenous and Western paradigm clash. He is justly critical of some western clinical practitioners who regard their knowledge as "culture free" (p. 336) and diminish Native American therapeutic interventions as "mere aesthetic performances, religious traditions, superstitions, even drug abuse or manifestation of mental illness" (p. 337). My narrative is an example of such a paradigm clash that Calabrese (2008) speaks about. The imposition of psychiatric diagnostic categories "developed with Western nosological categories in mind" on an ethnic client and/or institutional practices could result in psychiatric misdiagnosis (Bhugra & Bhui,

2001, p. 239). The cost of erroneous diagnostic labels, Bhugra & Bhui (2001) remind us, is non-delivery of appropriate treatment, a deferred intervention, and/or an unnecessary delay in help-seeking behaviour.

In this multi-cultural, multi-ethnic, and multi-racial society, it is then imperative that helping professionals, in designing health care policies and treatment programs, take into consideration other factors such as the client's religious and spiritual beliefs, familial context, as well as their meaning of health and preferred help-seeking strategies. Calabrese (2008) emphasizes the importance of acknowledging unique and heterogeneous ways of understanding the world (such as the cultural meaning of health, norms of sexuality, childbearing, etc.). Morley (2003) advocates a critical approach to social work that privileges the service users' *meaning* of a particular behaviour within the larger socio-cultural context. Her central message is: since social work has its own code of ethics that are not connected to the medical model, why does social work, like medicine, pathologize people experiencing psychological distress? Here, she is referring to the 'psychiatry-social work' partnership I spoke about earlier. My answer to her is: Social work, like psychiatry, is a site of power that engages in *truth games*. Therapy, as a truth game, produces the madman/the griever as an "object of *social work knowledge* and as a subject for themselves" (Foote & Frank, 1999, p. 163, emphasis mine).

One could view the efforts to improve the cultural validity of DSM-IV by introducing culture-bound symptoms (description of culturally specific psychiatric syndromes) as a step in the forward direction; it validates those individual differences that are rendered invisible in the diagnostic encounter when illnesses are perceived through the western lens. Nevertheless, psychiatric labelling could be detrimental. Engstrom & Okamura (2004), for instance, convincingly argue that pathologising symptoms of trauma has serious implications for work with refugees. These authors state that "Using PTSD and other psychiatric diagnosis with torture survivors removes the focus on the socio-political context of torture, individualize[s] the suffering, and negates important work on prevention, gaining impunity for victims and exposing the causes" (p. 303). It is important that mental health professionals clarify the health related issues with the client rather than forcing certain behaviour to fit within the DSM categories. Such communication requires a shift in perception. It means that the health professional as the 'expert' would have to drop the schema that his knowledge necessarily leads to effective intervention in all situations. He must be willing to treat the client as an expert of his own situation and to seek knowledge from him about what life is like for him by giving him an opportunity to speak about his notions of mental health and recovery (Dean, 2001).

Getting back to my earlier point, the mere inclusion of cultural related symptoms in DSM may be helpful to some degree, but it would not necessarily lead to a holistic understanding of the health of individuals from that cultural group. It is a 'bandaid' approach to inclusiveness. Unless the producers of DSM take into account contextual factors (poverty, racism, sexism, violence, etc.) to understand illness and prescribe treatments, include voices of marginalized groups, pay attention to gender bias, and address the political nature of mental health concepts, its detrimental effects on people's lives will continue to outweigh its usefulness as a mental health assessment tool.

Foucault's work is critical and transformative. He forces us to problematize our privileges as scholars working within the Euro-centric and patriarchal discourse of mental health. His words disturb our epistemological beliefs, demanding us to confront shifting realities, pay attention to how we do things, and assume responsibility to how our status as health scholars contributes to the production of discourses that maintain the status quo and perpetuate injustices (Chambon, 1999; Foote & Frank, 1999). Foucault's insights can help social workers link the self and society, personal and political, and theory and practice, thus generating knowledge about how institutional practices and social discourses sustain the speaking subjects and produce objects of which they speak (Chambon, 1999; Holstein & Gubrium, 2005; Scheurich & McKenzie, 2005).

Moving Forward

The saga of madness is intimately related to the saga of my institutionalised self. It is a tale of nuances, of complexity, and of suffering. Time and again I

wake up from the terror of being strapped to the bed. The intimate conversations with my diary helped me cope with the aftermath of that traumatic experience of institutionalization. As I reread my words, some of them lack coherence. The stains on the pages bring back old memories. Indeed! My writing is messy just like my life. My story is very much related to my life; it is tainted by my experience, and it is born from my heart and head (Richardson, 2001).

Writing, reading, editing, reflecting, analysing, and sharing my story with other scholars has been extremely painful. This process of reliving one's experiences through text, as Ellis (1993) points out, "may not be attractive to everyone" (p. 727). My intensely personal narrative is vulnerable to a series of criticisms that other autoethnographers and storytellers encounter: i.e., it lacks theoretical sophistication, it is not scholarly, it compromises ontology, and so forth (Ellis, 1993; Ronai, 1995; Richardson, 2001; Vickers, 2002). Nevertheless, I felt compelled to write through this pain and the fear of being branded with harsh labels. It is possible that through the telling of my journey I connect to others' similar experiences. The process of writing helped me face the demons that were still trapped in my mind after all these years and reclaim my experiences. Each time I write, I discover something about my selves. This self(s) keeps shifting and growing whenever it encounters other selves and society.

My knowledge – political and personal – surfaces from my particular location in my particular bodies (selves) with particular feelings, experiences, and desires (Richardson, 2001). Having lived in the body, mind, and spirit of my institutionalised self and positioned in a subordinate position in society, notions of exclusion and marginalization have acquired new meanings. As a researcher and scholar, I am more determined to engage in the kind of academic work that opens up safe spaces where the voices of the 'marginalized Other' can be heard. Certainly! I am willing to problematize my speaking subject position.

My institutionalised self does not exist in a vacuum. She is silenced by the gaze of the psychiatrist, the academic, the government, and society. Some of you may be touched by her. You may genuinely want to dialogue with her. Perhaps you are caught up in your dominant constructions and are unsure how to negotiate the anxiety and discomfort around *not knowing* the cultural Other. Your epistemological and ontological beliefs clash with her world view. Societal rules of morality, the social work code of ethics, and funding cuts further restrain you from reaching out to her. As guilty as you feel about your paternalism, deep in your heart you may yearn to emancipate her. Caught up in your social codes and practices, you feel inadequate. This encounter between your *not knowing* self and her *marginalized* being, however unsettling, could be transformative.

I confess that I don't know anything for sure. All the same, I argue with Calabrese (2008) that "Psychotherapeutic intervention is not something that can be standardized, manualized (encoded in the instructions of a 'how-to' manual), and regulated…It is not owned by any particular cultural group or professional organization…" (p. 334). In fact, there is no universal theory and there *never will be* one through which you can get to really know me, the Foucauldian madwoman. I suggest that you keep an open mind, learn to listen, and risk *not knowing*. Perhaps then you may get a glimpse of me.

Glossary

Antim Sanskar – "*Antim*" means Final. "*Sanskar*" means ritual. In Hinduism, it means the final ritual that is carried out upon the death of an individual.

Preta – signifies a "ghost." Hindus believe if a proper death ceremony is not conducted, then the soul of the deceased may linger and suffer as a ghost in the earthly realm.

Pitrs – represent the departed spirits of Hindu ancestors. They are remembered through annual ceremonies.

Suhagan – means being married. To be married is considered auspicious by Hindus. The traditional blessing that elders give married women is: *sada suhagan raho*, meaning may you be happily wedded until your death.

Shamshan ghat – is the Hindu cremation ground. Married women are dressed in their wedding *saree*

for the death rite and their ashes dispersed in the holy Ganges river.

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