

MPC MAJOR RESEARCH PAPER

AUTOETHNOGRAPHY & GOFFMAN'S *ASYLUMS*: RE-STORYING MENTAL ILLNESS

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## Abstract

Mental illness narratives occupy a small, unstable place within critical discourse. Within both research and social practices, mental illness is often seen as a limitation instead of an alternative way of knowing, and thus, personal accounts are swept aside in favor of more “objective” research. In 1961, famed sociologist Erving Goffman published *Asylums: Essays on the social situation of mental patients and other inmates* after observing the daily life of a mental institution. While the book breathed life into the deinstitutionalization movement, it also undermined the narrative autonomy of the patients that it spoke for. In this paper, autoethnography is used to complement and challenge Goffman’s research, while arguing that there is a better way of positioning the patient narrative within mental health research. It is a way of reconciling my identities as a person with mental illness and an academic, and bringing lived experience to the forefront of mental health discourse, where it belongs.

## Pre-Preface and Acknowledgements

*We are restrained and limited by the kinds of cultural stories available to us. Academics are given the “story line” that the “I” should be suppressed in their writing, that they should accept homogenization and adopt the all-knowing, all-powerful voice of the academy. But contemporary philosophical thought raises problems that exceed and undermine that academic story line. We are always present in our texts, no matter how we try to suppress ourselves.*

*- Laurel Richardson, Fields of Play (1997, pp. 2)*

Let’s just get it out of the way – I have compiled a weird piece of academia.

When someone tells you to write an MRP and you tell them you’re going to write stories instead, and they say *okay, do it*, you’re faced with a tricky problem. How do you justify a methodology that relies on personal bias and lived experience? Also, how do you not make your classmates hate you for having such an awesome supervisor? The answer: write it in secret, eat a lot of rainbow sorbet, and know all the while that alternative stories deserve to be told in alternative ways. I was left with the question: What sort of scholarly methodology will work for someone who missed 30% of her morning classes due to the side effects of anti-psychotics?

I think it’s safe to say that methodology is a reflection of the researcher, and I didn’t come here to tell my story in a neat little package that fits into the footnotes of major research. I came here to challenge perceptions of mental health discourse, and that’s why I chose autoethnography. It’s a tiny little piece of revenge for all the years my story would have been discredited by “real” researchers, and a way of reaffirming that alternate ways of learning and knowing have real value in the real world.

A big thanks goes out to my supervisor, Dr. Mason, for supporting my out-of-the-box ideas; my second reader, Dr. Tiessen, for not shutting this party down; and Lauren for trapping me in coffee shops and making me write this thing while manically sipping lemonade. It was a bit too sour but I rolled with the punches. Big ups to my parents for birthing me, my boyfriend for being big spoon, and Michael Landsberg for lighting the mental health fire under my butt. To Body Blitz Spa for letting me sit under your magic waterfalls every time I finished a draft (for only \$60!). Also shoutout to the MPC program for letting me learn about things I actually cared about, and to the yoga place I stalked for 30 days straight while banging this thesis out. I drank all your free tea and you were just like “Namaste” and I love you for it.

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## Preface

Dear Erv—

Can I call you Erv? I'm going to call you Erv. As a communications graduate student and eye-rolling millennial, I'm probably not your first choice for a beyond-the-grave pen pal, let alone a critical challenger to your ethnographic research methods. But I'd really like to think that under other circumstances, we would have shared a beer and gotten along (just kidding, I don't drink). Neither of us seems to give two hoots about censorship, and I agree with the basis of your methodology – that “any group of persons – prisoners, primitives, pilots, or patients – develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject” (Goffman, 1990, p. ix-x). And so, armed with your sociological notebook and questionable ethics, you inserted yourself into the American psychiatric system as a fake athletic director<sup>1</sup> from August 1954-1957, and faithfully recorded your findings in *Asylums* (1990):

My immediate objective in doing field work . . . was to try to learn about the social world of the hospital inmate, as this world is subjectively experienced by him. I started out in the role of an assistant to the athletic director, when pressed avowing to be a student of recreation and community life, and I passed the day with patients, avoiding sociable

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1 From autumn 1954 to the end of 1957, Goffman studied ward behaviour in the National Institutes of Health Clinical Center by posing as the assistant athletic director of the facility. *Asylums* is largely based on the observations made during this experience.

contact with the staff and the carrying of a key. I did not sleep in the wards, and the top hospital management knew what my aims were.

(Goffman, 1990, p. ix-x)

Based on what you observed, the central feature of a total institution is “the breakdown of the barriers ordinarily separating these three spheres of [sleep, play, and work]” (Goffman, 1990, p. 6). While you argue that allowing yourself to be psychiatrically committed would have limited your study further in terms of data reach, I believe that the greatest limit in *Asylums* (1990) comes from your privileged unfamiliarity with the total institutions that you explore. And instead of acknowledging this privilege at the onset of your study, you defend the strict social structures that dictate the position of the patient narrative in academic constructions of mental illness:

The world view of a group functions to sustain its members and expectedly provides them with a self-justifying definition of their own situation and a prejudiced view of non-members, in this case, doctors, nurses, attendants, and relatives. To describe the patient’s situation faithfully is necessarily to present a partisan view. (For this last bias, I partly excuse myself by arguing that the imbalance is at least on the right side of the scale, since almost all professional literature on mental patients is written from the point of view of the psychiatrist, and he, socially speaking, is on the other side). (Goffman, 1990, p. x)

You are correct in pointing out that the canon of critical discourse on institutionalization and mental illness is carried by the writings of psychiatric professionals, but that does not necessarily mean that this perspective should outweigh the knowledge gained from lived



experience, or overshadow it in the development of relevant public policy. Similarly, while *Asylums* (1990) seeks to address the stigma surrounding mental illness, your use of participant-observation ethnography not only promotes social distance between the patients and researchers, but also dehumanizes their struggles. The easiest example of this is your continuous use of the term “inmate” to describe the people you spent three years learning about.

I was once an inmate. In March 2013, I was hospitalized for bipolar disorder at Rouge Valley Hospital for an entire week, and it shook the very roots of my identity. As a graduate student, I later read *Asylums* (1990) with a mixture of shock and familiarity, recognizing ward situations but remembering them in a completely different light. Thus, my Major Research Paper is an attempt to reconcile my identities as both a mentally ill person and an academic. I will be using autoethnography as a tool to examine the week I spent in a psychiatric ward, contrasted against the theoretical framework of *Asylums*. Why autoethnography? Well for starters, I’m a creative writer by trade, and I’ve never quite stuck to conventional forms of research. Ellis, Adams, and Bochner (2011) state that “autoethnography is one of the approaches that acknowledges and accommodates subjectivity, emotionality, and the researcher’s influence on research, rather than hiding from these matters or assuming they don’t exist” (p. 2). I think that embracing the presence of subjectivity within research is especially important when analyzing accounts of psychiatric illnesses – a field in which subjective experiences are routinely converted into medical diagnoses. You simply cannot separate emotion from reason when it comes to mental health, at least not without dehumanizing the people you purportedly represent. It’s just too complex to compartmentalize.

At one point in the preface, you admit that your perspective may be a bit too much of the “middle-class male” (Goffman, 1990, p. x), and that’s honestly not your fault. Historically speaking, that’s who got to call all the shots. As Ellis, Adams, and Bochner (2011) point out, “for the most part, those who advocate and insist on canonical forms of doing and writing research are advocating a White, masculine, heterosexual, middle/upper-classed, Christian, able-bodied perspective” (p. 3). Seeing as I’m only two of those things (and many people are even less accommodated), I think there should be more room within critical discourse to accommodate other ways of knowing. Without a wider lens, how can we properly understand the people we study, and learn from them? The exclusion of lived experience is a form of othering within research practice that limits the meaning of our conclusions.

That’s what this project is all about. I’m writing an autoethnographic research paper in response to *Asylums* (1990), not because I think you did a bad job, but because it’s *about* the patients, not *from* the patients. They’re treated as objects instead of participants in the formation of critical research about their own life paths. As a patient, I think there should be room in academia for both of our perspectives, so that we can start an honest conversation about mental illness and what it means to be “sick.” However, othering to this extent is not that easy to fix. *Asylums* (1990) contributed to the dehumanization of people with mental illness. You discredited our personhood and questioned our autonomy. As Fisher and Freshwater (2014) note, “The mad have been excluded from the epistemic as well as the social community, their voices disregarded and dismissed as meaningless. Their struggle must include being believed as credible knowers, as well as being merely heard” (p. 202). I have to come back from a history of

oppression to write this paper, and even then it will still be broken. Your legacy is great, but you put a lot of people in tightly-sealed boxes to get there – and we’re ready to come out.

There are few opportunities for people with stories like mine to share their experiences in a way that is valued by the larger public. Autoethnography, as a methodology, provides a platform with which to explore my traumatic experience in an academically viable way. Supported by Fisher and Freshwater’s (2014) methodology, my research paper will combine creative and critical to “enact [my] own forms of resistance . . . prompting a form of ‘decolonization’ through the telling and construction of stories, whereby people represent themselves rather than being spoken for” (p. 202). Using the journal I kept during my stay in the hospital, I will be writing four creative nonfiction stories, each one pertaining to a chapter of *Asylums*. Every story that I write will be a reflection on your work – an insider’s view of institutionalized culture. I’m not trying to prove you wrong or right, but I want to offer an alternative view of treatment, recovery, but most importantly, patients.

Before and after each story, I’m going to write you a letter (not an emotionally angry letter, just a critically angry letter). The reason why I’m writing you letters instead of a conventional research paper is that I want to show you the power of human stories – that just because something isn’t cut and dry doesn’t mean it’s not worth reading. Through the critical analysis of my lived experience, I will challenge Erving Goffman’s assumptions and ask how we can better value the position of the patient narrative in academic literature. I’m grateful for the research you have contributed to the world of psychiatry, but I think you might have missed out on the best part of your experience.

Inmates are people; inmates are survivors, and if anyone should be rewriting the book on psychiatric institutionalization, it should be us.

Cheers,

- Leanne

## Literature Review

### Goffman and the Dawn of the Mental Illness Narrative

Goffman's *Asylums* clearly articulates many of the contradictions that exist within the mental health system. Goffman's depiction of total institutions correctly outlines the ritual behaviour of both patients and caregivers, with successful institutionalization resulting in the relegation of patients to a passive role. Divided into four sections, Goffman's analysis of institutionalized life shows a system characterized by social control rather than medical advancement. Through a combination of ethnographic observation and personal insights, Goffman questions the validity of psychiatry as a medical field, and theorizes that mental illness is largely socially constructed. I believe my use of autoethnography is a challenging counterpart to Goffman's participant observation methodology.

The ritual practice of escaping self-stigma is a crucial theme to many traditional recovery stories. With that in mind, Goffman's *Stigma* is an ideal companion to *Asylums*. In *Stigma*, Goffman relegates mental patients into a category that leaves them "disqualified from full social acceptance" (130). However, this may be due to the limitations of his methodology – while examining the autobiographies of others is a very rich qualitative method, he cannot fully understand nor contextualize for readers the meaning of stigma without considering his own place of privilege within society. Goffman argues that everyone is a victim of stigma, yet he writes only about traditionally marginalized groups, thus reinforcing negative stereotypes. In contrast to Goffman's exploration on "the management of spoiled identity," I will be exploring self-stigma as I reconcile parts of my own identity. Furthermore, while it may not warrant its own

chapter, Goffman's (1974) *Frame Analysis* will constitute the theoretical roots of my narrative process. Goffman (1974) argues that people with mental illness should not be considered capable actors in their own life experiences, and often places them in the category of a "broken frame." In his terms, this means a lack of identification within society, and the inability to communicate in a healthy manner.

Finally, I will analyze "The Insanity of Place," an essay written as an extension of Goffman's initial observations of the mental health system. This article explores the connection between mental illness and havoc, and elaborates on the role of family and presentation in society. It is also a marked departure from Goffman's pure social constructivism in the sense that it acknowledges and incorporates biological perspectives in its description of mental illness; I plan to use this article to demonstrate the trajectory of the deinstitutionalization movement and modern academic attitudes towards mental illness.

### **Criticisms of Goffman**

My challenge to Goffman's theories stems from his relegation of people with mental illness to a passive role. However, when examining collections of critical perspectives on Goffman's (1990) work, I have found many of his initial stigmatizing attitudes remain in current sociological interpretations of mental illness. For example, while Adlam et al. (2013) provide an interesting collection of perspectives on Goffman's *Asylums*, even after 50 years of medical innovation, the perspective of the patient is still devalued. It is alarming that a widespread collection on mental illness hopes to spark discussion "from service users, carers, clinicians, and academics and researchers across a range of disciplines" (p. 605) without once discussing the perspective of those with lived

experience. In my comparison of Goffman's (1990) research to my own institutionalization, I will also be contrasting Adlam's (2013) experts against my own experience.

Shalin's (2014) case study surrounding *Asylums* takes, understandably, a much more comprehensive approach to evaluating Goffman's (1990) research. In her research, Shalin (2014) makes a point of recognizing *Asylums* as a work of self-ethnography in which Goffman (1990) employs biocritical hermeneutics to relay his sociological observations of an insider culture. Shalin's (2014) evaluation of narrative in *Asylums* also discusses Goffman's dichotomy between "mental" and "medical" phenomena, a concept that I wish to apply to my own experiences. I will also be using Shalin's 2013 article, "Goffman on Mental Illness: Asylums and 'The Insanity of Place' Revisited," to draw parallels between my autoethnographic research methods and Goffman's own methodology. Shalin (2013) critically analyzes the timeline of Goffman's views on mental illness in relation to Goffman's family struggles with bipolar disorder. This article will reveal another layer of Goffman's work and challenge the ostensibly detached nature of his participant observation.

Furthermore, I utilise Babb's (2014) article, which explores the stigma behind labeling, and how behaviour seen outside of typical social frameworks can be interpreted as hostile, and is therefore socially sanctioned. This perspective helps explain Goffman's idea of mental illness as a form of social control, despite the fact that the article still frames people with mental illness as social offenders rather than justified cases of sickness. In contrast, Smith (2005) explores Goffman from a phenomenological standpoint, focusing on the presence of the other in his work. The analysis focuses on

individual experience as dependent on the commentary of others; that Goffman presents victims of stigma as people who have valued their own perspective less than that of everyone else. This is especially insightful to my paper as this contradicts Goffman's categorization of the mentally ill as "faulty actors." This implies that they can regain their agency by reclaiming their stories, and reframing them with individual meaning.

### **Autoethnography and Narrative Inquiry**

In order to apply these theoretical criticisms to my personal experience, I will be using autoethnography as both a creative and academic methodology. In order to shape my story according to academic conventions and expectations, I will be modeling my own experiences on the narrative structure of *Asylums*, while maintaining a personal tone that stands in contrast to Goffman's (1990) clinical removal from his subjects. Ellis, Adams, and Bochner (2011) describe autoethnography as "an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience" (p. 1). In order to provide insight into a place most academics don't see, I will be addressing the culture of mentally ill patients within an institutionalized setting. When a member of society loses all control – over their clothes, their mealtimes, the lengths of their showers – the things that they can control become much more important to their respective identities. As a member of this culture (an *insider* as Ellis et al (2011) would call it) I will be analyzing past events in order to present them to cultural *outsiders*. This process will be facilitated by Ellis et al.'s (2011) overview of the stylistic and structural purposes of autoethnography.

I will also be using Young's (2009) assortment of memoirs as a resource to structure my autoethnography. In these memoirs, Young (2009) challenges the social



construction of mental illness as something that we should be ashamed of; she uses four memoirs to challenge the discourse and language surrounding the sick, showing that they are much stronger than society is willing to credit them. It is this reinterpretation of language that I wish to draw from for my own research.

Similarly, Baldwin (2005) argues that humans are narrative beings, and that mental illness severely diminishes our ability to construct a coherent self. In creating alternative frameworks for mental health patients, Baldwin attempts to equally accommodate different understandings of reality while examining the ethics of narrative therapy – the sharing of stories equates with social power. For my paper, I will use this resource in order to better understand power structures within the mental health system.

Finally, Fisher and Freshwater (2014) tackle the fundamental ideal of a unified self, and challenges it in relation to mental health narratives. Narrative methodology allows for agency in the subject while addressing issues of oppression – the opportunity for marginalized voices to author their own stories brings with it a subjective transformation. I examine this theory in combination with Goffman's work to try and find a platform for autoethnography amongst mental health discourse.

## **On the Characteristics of Total Institutions**

To my dearest Erv—

You said that “the total institution is a social hybrid, part resident community, part formal organization; therein lies its special sociological interest . . . in our society, they are the forcing houses for changing persons; each is a natural experiment on what can be done to the self” (12).

I’m not quite sure that “natural” is the best adjective for describing the psych ward, but I won’t argue that it changes a person from the inside. When I think about my first day in Rouge Valley Hospital, I think about how I tried to differentiate myself from the people around me, how badly I wanted to maintain social distance from the situation I was in. But in a total institution, your social situation becomes synonymous with every other part of your life, and instead of splitting your identity between social spheres, you lose the ability to shape-shift, and have to reconcile yourself with a single version of who you are – and that image of you may be completely at odds with who you were before you got sick. The way you choose to define yourself at the onset of your institutionalization – through the greatest challenge to your personal identity – is something that never completely removes itself from your consciousness. It is the beginning of your documented story, so you’d better stick to it.

- Leanne

## **Never Have I Ever**

It was a lot like summer camp, but with heavy barbiturates.

First you had to find your place, between the shit-throwers and the screamers, the mildly delusional and the ones who “didn’t belong here.” Then you had to take a long, hard look at yourself and decide how much you wanted to belong.

“Miss, d’you know what time’s my shower?” A bedraggled man in a hospital dressing gown stopped me on the way to the common area.

“I’m sorry, I really have no idea.”

He was the third person in the last hour to ask me a question that could not possibly be answered by someone who had just checked in last night. At least I was fitting in already.

The common room looked like an Ikea display gone wrong, like its Swedish pride had been overrun by grimy fingers and sweaty palms holding on for dear life. A small, shrivelled man occupied the largest and most central chair in front of the television. The converter was shoved into the crack behind him, and his neck snapped back and forth like an alligator, daring anyone to take it.

The others didn’t seem to want to challenge his authority over the couch. They clustered in the dining area, half-heartedly dealing out cards and then forgetting about them. Decks of cards were the number one guilt import from concerned family visitors. If we were smart, we would have used them to start a fire.

“So I zipped my winter coat over my head, I jumped into the deep end and waited to die.”

She said this with a nonchalant flip of the hair, as if living and dying were all the same to her.

“Didn’t it make you float?” I blurted out. “The coat, I mean.”

The hipster girl’s eyes fixated on me, then narrowed.

First rule of the psych ward: don’t question the psych ward. That includes family history, diagnoses, medications, and most importantly, how you got here and when you can leave. If you can leave. There’s at least three people who introduce themselves as our Christ the Lord, and don’t you dare tell them otherwise.

“What are you in for?” she asked sweetly.

I saw how this worked. Everyone’s favourite game at summer camp was “Never Have I Ever,” and the best way to build street cred is with a killer story, you know – differentiate yourself, give yourself an identity.

“I have bipolar disorder,” I said quietly. I wasn’t sure if having an identity would benefit me at this point. My understanding of psych wards was that they were something you survived, floated in and out of, and then never addressed again. It was the kind of thing you hid on a job application, like your two years of pet-sitting and a druggy ex-boyfriend.

“She’s a nurse,” piped up the man in the chair. “She’s a narc.”

Heads swiveled in my direction like a bad Western.

I sighed. “I’m not a nurse, or a narc. I’m just in here to get some rest.”

The lord of the chair rose to his feet, and shuffled his slippered feet towards me to examine my medical bracelet. “Huh. You don’t look like a patient.”

And that’s the thing – I don’t look like anyone from One Flew Over the Cuckoo’s Nest, or whatever else people associate with psych wards. I was a middle-to-upper class 20 year-old with a university education, steady history of employment, 5 scholarships, a boyfriend, and a supportive family. I didn’t belong in this story, and even the people around me could tell. But mental illness doesn’t care what role you’ve been cast into. It puts you on a playing field that isn’t even but doesn’t discriminate in its unfairness either.

I could have told them about the time I jumped out of a 40 ft. tree and almost drowned, or the time I saw snakes coming out of my boyfriend’s throat. But that would have been conforming to what was expected of me, and I’ve never been too good at following the rules.

“I’m just here to adjust my meds. Won’t be in long.”

The man returned to the couch, and the hipster girl continued regaling us with her drunken exploits. I sat there wondering if I didn’t belong here, and I didn’t belong in the real world, if there was even a place left for me anymore.

It was a millennial’s worst nightmare – they took my laptop and cellphone, placed them in a safe-deposit box behind the nurses’ station, and directed me towards a grubby hallway payphone. It wasn’t so much the ownership but the loss of anonymity that pained me. I hadn’t called collect since Grade 6 and I wasn’t about to explain to friends why I didn’t have access to a phone, and without my laptop, I couldn’t feel like a writer

embarking on an undercover investigation – no matter how badly I wanted to rationalize my situation. I just felt sick, broken, and far from home.

The staff treated me like a small-town beauty queen. They could smell the privilege wafting off my Lululemon hoodie, and decided that it wasn't worth their time. The nurse who admitted me was snide and competent, and told me to hide my things – that there was no need for my Clinique makeup here, that there was no one to impress. I wasn't trying to impress anyone – I just wanted to maintain some semblance of normalcy in the mornings. There was a certain comfort in applying mascara that you'd probably cry off in group therapy. I sensed that she thought my occupancy was a waste of space – that there were too many drug-addicts and worst-case scenarios roaming the hallways for her to have to worry about protecting me. I was the only patient without a roommate, except for the woman who screamed all night.

At floor dinner that night, I met two people intimately related to my classmates at school, and experienced a wave of panic that I had never felt before. I had been mentally ill my whole life, diagnosed for 3 years, but it had always felt more like a Post-It note than anything else. But now there was a paper trail, people who knew me not as Leanne the English major, but as Leanne the mental patient. One of the girls was the older sister of someone I grew up with – a sister that had never been mentioned at sleepovers or recess. Maybe it was more convenient for her to live life as an only child. I wondered if I could become invisible too, if all my awards and team jerseys and stories would dissipate overnight.

Rob wasn't allowed to wear his own clothes. He shuffled into the dining hall in makeshift hospital slippers and two robes, explaining that his heart was too big to just fill

one. I agreed – Rob was a teddy bear, eating chicken pot pie with a long, red scratch up his arm. He told me about it over dessert, how it all snowballed until he was standing in his kitchen with a knife. It wasn't the unemployment or the breakup, or even the bipolar diagnosis – just the feeling that it was all inevitable and no amount of phone calls from his mother could stop it.

“You should tell her that you're here,” I said softly.

“She's already been through enough,” he said.

“You fucked the run!” yelled Wendy. I should probably have mentioned that we were playing gin rummy with the wife of an Amish Mafioso.

“What are you really in for?” he asked, after Wendy had fallen asleep in the common room armchair.

I didn't know how to explain that there was no dramatic climax to my hospitalization, just a monotonous feeling that I wasn't in the right place, that I came here with a firm sense that this would fix me once and for all, and that optimism was fading fast.

“I used to be perfect,” I said blandly. “Until I stopped getting out of bed. So they put me on Prozac, and I went completely manic. Tried to kill myself on the comedown, and now I'm here.

“That's a lot for you to handle,” he said.

“But that was years ago – now I’m just scraping by and I’m tired of just scraping by. I remember what it was like to live, and I want it back so badly but can’t seem to find a grip. I’m here because I don’t have anywhere left to go.”

We watched Wendy sleep for a while, her mouth slack and mine tightly pursed. For a writer, I don’t do character development well – especially my own.

“Well, you can always come to me,” he said, squeezing my hand.

I went to bed that night feeling more like myself, despite the nurses checking under my tongue for unswallowed pills. The one constant in my struggle with bipolar has been the support group around me, and even if I couldn’t control my medications or their side-effects or even my brain, to choose my family was enough.

### **Critical Analysis**

Dear Erving Goffman,

So there you have it – total institutions are glorified summer camps, and the only way I survived was by maintaining some semblance of my home life. You once said that “it is characteristic of inmates that they come to the institution with a ‘presenting culture’ . . . derived from a ‘home world’ – a way of life and a round of activities taken for granted until the point of admission to the institute” (12). The thing I took for granted the most in the outside world was my ability to “pass,” as you call it. I was high-functioning, and there was no visible mark of stigma on my life. But once you’re inside the psychiatric system, that label is superglued to every word you say. It’s hard to feel like the same person – or even a person, for that matter. I came in with a lot of the stigmatizing



perspectives that I would later face myself, and eventually lose through the depth of my experiences.

You state that “when entrance is voluntary, the recruit has already partially withdrawn from his home world; what is cleanly severed by the institution is something that had already started to decay” (15). By the end of my stay at Rouge Valley General Hospital, the thing that had decayed the most was any sense of hope. It wasn’t the bleak, industrialized feel of the ward, nor the random outbreaks of violence or even the terrible food that broke me. It was the lack of voice I had in my own medical treatment. The stigmatization of mental illness was quite apparent in the psych wing – patients had no input on treatment nor therapy, and were judged based on their level of visible competence. As Clive (2005) observes, “we have a tendency to approach people with severe mental illness . . . as recipients of our care, service, and narrative constructions rather than contributors to our own narrative constructions . . . in this way, we are curtailing one aspect of his or her narrative agency and thus one aspect of the Self” (p. 1027). Especially in the case of voluntary admittance, removing the patient’s contributions to his or her own care has the potential to further self-stigma, and circumvent an effective patient-doctor relationship.

Erv, I would counter your accusation of withdrawal from society with the argument that actively seeking psychiatric help pre-crisis suggests a strong moral alignment with guiding social principles, and that voluntary patients are scrambling to hold on to their home worlds by acceding to dominant social structures, namely the psychiatric system. It is an autonomous choice to give up whatever remaining control you have over your life – despite your debilitating illness – for the chance of being accepted

into society with (mostly) open arms once you return. That being said, the benefits of medical care have been shown to be increased by the co-existence of the medical record and patient's self-devised narratives (Grant, Phippard and Short, 2015).

As an incoming mental patient, there is a rare dual pressure applied to people – the need to prove that you are sick enough to be there, but not sick enough to never leave. Your recovery story becomes a central part of this trajectory. The process begins with careful censorship that is then applied to mandatory group therapy, social interactions and medical consultations. The re-storying of mental illness becomes not an individual effort, but a guided journey: “During therapy, [patients] seem willing to tolerate if not espouse, the interpretation of events invoked in various direct and indirect ways by the therapist” (Goffman, 1974, p. 385). Buying into institutional organization is an implicit part of survival on the inside – the hospital is a purgatory that relies on role dispossession in order to maintain control (or as otherwise phrased, “protect”) the individuals it houses.

Having written an entire other paper on your 1974 endeavour, *Frame Analysis* (I must really like you or something), I'm well-versed in your opinions on the autonomy of people afflicted with mental illness. You say:

It is possible to try and describe the sense in which an individual defined as insane is seen as an incompetent, faulty actor . . . A point to note, however, is that it is a part of our belief regarding insanity that . . . the individual can remain locked in his “illness” forever. (p. 115)

I think your sociological interpretation of mental illness is at odds with medical definitions of psychiatric disorders. It is convenient for sociologists such as yourself to

stigmatize mental patients in your work, as it reinforces your own worldview. Remember your words from the preface? *The world view of a group functions to sustain its members and expectedly provides them with a self-justifying definition of their own situation and a prejudiced view of non-members.* In this case, you question psychiatry and the credibility of mental illness because they exist outside of your sociological structures. To question the efficacy of total institutions is within your acceptable range – however, to question the personhood of real people is not. Shalin (2014) states that “it would be a stretch to say that Goffman denied the organic roots of mental illness in his early work, but he effectively bracketed the psychosomatic factors, downplaying their significance in understanding psychiatric disorders and explaining a moral career of mental patients” (p. 127).

Shalin (2014) also notes that your interpretation of mental illness was essentially “a social construct designating a spoiled identity that colluding others successfully impose on a victim” (p. 124). Based on the ableist language used throughout *Asylums*, I would have to agree. Even by referring to a patient’s recovery as a “moral career,” you are undermining the legitimacy of their personal and medical journey. To say that mental disorder is a moral issue is to question its legitimacy. In the next chapter, “The Moral Career of the Mental Patient,” you claim that “An important aspect of every career is the view the person constructs when he looks backward over his progress; in a sense, however, the whole of the prepatient career derives from this reconstruction” (Goffman, 1990, p. 145). I would argue that your stigmatizing views on mental illness and hospitalization derive from a reconstruction of prevailing social attitudes throughout the inception of institutionalization. It is far easier to reinforce the helplessness of mental

patients than admit that the social support wasn't there for them. With that in mind,  
here's chapter two – also known as the prepatient phase of my moral career, the turning  
point that got me committed.

Hugs,

- Leanne

## **The Moral Career of the Mental Patient**

I stared hungrily through the glass, looking for an out somewhere between the chocolate croissants and Timbits. I ordered a sprinkled donut, figuring it was as good a time as any to start cashing in on my pregnancy cravings.

He was sitting in the corner, hunched over his double double. I slid into the seat across from him and tried to strategically manoeuvre my donut from its wrapper without releasing a wave of sprinkles. It was a complete and utter failure.

“I can’t have a kid right now.”

It was a real clean slice of cake – dealt as swiftly as a Jesus pamphlet on the street, pressed warmly into my hands before I could reply, “No thanks, I’m not really religious.” Every pro-choice and pro-life poster stapled to my high school’s walls peeled, boiled and pressed into an inconvenience. Maybe I should have been more devout.

“I mean, I’m not saying it’s ideal,” I said between mouthfuls of pastry. “I’m just saying that my period hasn’t actually been a thing in a month and a half and I thought I should tell you.”

“And you’re sure it couldn’t be anyone else?”

The bottom of my stomach recoiled. “You know it’s not anyone else.”

“Well, I don’t know. With your – you know, it’s not like we’re exclusive or anything,” he said, eyes flickering towards the grimy window. I wanted to streak my finger through the dirt, make sure I was still breathing.

“With my what?” I said. Steady job, university education, fantastic tits?

He stared into his coffee.

*Don't stick your dick in crazy.* I first told him that I had bipolar just after Halloween – emphasizing the *had* and not *was*, as if it felt any different. I wasn't wearing my cat ears anymore, but when I reached for him, he looked scared – almost cornered. “What do you want me to say?” he said, kicking the covers off with his legs. “It's like I don't know who I'm gonna wake up next to.”

I lay beside him, my knees half-pulled into my chest, hoping that if I didn't move, he'd think I was the same.

I don't know why I thought he'd get it. Fourth year psych major headed straight for grad school – he rattled off my symptoms like ingredients in a recipe, and asked me if I was manic. He once called me beautiful. Second year English major losing track of her words, I spent a lot of time trying to figure out if I didn't feel the way I looked, or didn't look the way I felt. It's the kind of run around that makes your head spin.

“You can say it, you know. I'm not afraid of people hearing,” I said. I left out the part where I was afraid that he was.

“I know,” he said, looking up. “I'm just not used to it.”

I couldn't tell you when I got used to it – feeling predisposed to failure, like something in my blood had gone sour but I couldn't stop it from circulating. It might have been the moment at Christmas dinner where I found out my great-grandfather had blown his brains out, and I didn't really have all that much to live up to after all. I ate my pie quietly, unsure which was worse – further confirmation that my brain was fucked, or the knowledge that I finally had something in common with my family.

“You do, you know,” I said, rearranging my sprinkles like an Etch-a-Sketch. “Get used to it. There’s patterns. You start to recognize when things are getting bad, and you make adjustments.”

“Leanne, I told you it’s not about that.” His exasperation clung tight to my veins.

“Then I don’t understand what it’s about,” I said, my voice taut. I needed this to be about *it* and not *me*, as if my illness was something removed from myself. I wondered if he could sense it – the elevated lithium levels in my bloodstream compounded by a healthy sense of self-loathing. I asked him once why he liked to powerlift, and he replied, “So that I can be the strongest.” I asked myself how I could love someone whose definition of strength could fracture mine. I was sick, and not weak, but that didn’t mean that I was winning.

“It’s nothing against you,” he said, nervously twisting a napkin around his finger. “But you don’t know my family. They’re not like me. They don’t understand this kind of stuff – these kind of problems. I could never bring you home. They just won’t accept it.”

If I had to draw a road map of where it came from, it would jump from my great-granddad to my grandfather, from him to my aunt. My aunt to my dad, but not in the same way. He doesn’t have bipolar; I do. My cousin disappeared a few years ago and we found him in the river. My uncle has been missing for two months. But in my family, you don’t hear about anything until it’s absolutely necessary, until the subpoena arrives and they find themselves obliged to inform you what’s wrong with your head. Until you’re sitting in a Tim Hortons at 1 am, arguing over your hypothetical unborn child. Parenting at its finest.

“That’s such a cop out,” I spat. “You’re scared of my illness. You don’t think I’m stable.”

I wanted him to tell me to shut up, to grab my hands and kiss me in front of all the people who didn’t think I was crazy, who didn’t see my darkness. I’m used to being disappointed.

“I want to believe you, but I know better,” he said. “This is what I do; I know the patterns, I’ve seen the extremes. It’s hard not to code your behaviour–”

“Code it?”

He thought for a moment. “You know, the reckless spending, the hedonistic attitudes towards school, the risky sexual behaviour–”

“It’s literally just you!” I hissed. “Just you. For fuck’s sakes.”

I looked at the person I’d spent most of my evenings with for the better part of six months, and I couldn’t see him. All I could see was myself as a specimen; my tiny shriveled heart being studied for its weaknesses. This time, I couldn’t believe him when he said it wasn’t me – that I wasn’t a burden or a drain, or whatever girls worry about then they’re being little spoon while trying not to breathe too heavily. I felt like a problem, like my label was stitched into my skin so tightly I couldn’t move.

“I can’t have a kid right now,” I said. “I can’t have a kid, maybe ever.”

He didn’t say anything, didn’t touch me.



“My medication, it gives kids birth defects. If I want kids, I have to go off my meds for the whole pregnancy and pray that my mood stays stable enough to continue functioning as a human. Because I am functional, okay?”

People tell me all the time that I am high-functioning, which is actually term more suited for the autism spectrum than mental illness. I don't correct them anymore – I take my small win, and I work my safe, customer service job, and I dream of the day where I'm ready to do something bigger. Because I can feel it growing, even on my bad days. Today is a bad day.

“And God knows I have a lot of bad days – but they are still days, and I am still here, and when you say you can't have kids, it's not the same as me. It's just not. I'm sorry, but your “can't” doesn't break my heart, because it is a choice. I don't have a choice.”

His hand crept closer, initiated peace. Failed, too.

“I wanted kids,” I said slowly. “But what if I'm not always the same person they wake up to?”

I don't remember what he said after that, and it honestly didn't matter. My dad came to pick me up in the dead of the night from the seedy Tim Horton's across the street from the hospital, and didn't ask how I got there, who I was with, or why my face was streaked with both tears and sprinkles. He drove me right back to the hospital the next day.

My dad once told me that he watched me grow up with fingers crossed, because it always seemed like I would burn right out. He was right, but I didn't mind it at the time.

My father had only ever showed me how to live in the light, and I couldn't fathom changing my ways for a label that wasn't ever truly mine. Years later, I know that bipolar is a dogged companion, one that ignores changed addresses and unopened letters in favour of knocking on your door in the middle of Christmas dinner. I've started inviting it to the table in hopes that we can talk as old friends.

As we drove away, I wondered if my choice of an empty womb was based on my own insecurities, or other people's criteria for happiness, security, and love. I sure didn't have emotional security, and my happiness was a part-time tenant, but what I did have was love. Every now and then, I stop loving myself. I strip the colour from my own story, and wonder why it's bleak. But I have never, ever, stopped loving the people around me, and I never will. It's easier to look up at the stars than find your own light, and while the ride home that night was full of darkness, I believe that someday I will glow.

### **Critical Analysis**

Erv —

I think it's safe to say that my backstory is a little outside of your target group, and maybe that's because your target group seeks reinforces common perceptions of what it means to have mental illness, and mine challenges them. I think the basic linguistic premise is discernible through your use of "the mentally ill" and my preference for "people with mental illness." In my usage, personhood takes precedence over labels, and that's the way I want to explore the topic — as an element of the human existence, not a limiting factor.

That being said, I realize that the intersectionality between mental illness and a variety of marginalizing traits cannot be overlooked, and my story emerges from an unfamiliar place in stock representations of mental health. There is also the voluntary manner in which my psychiatric hospitalization began. As you describe this experience:

A relatively small group of prepatients come into the mental hospital willingly, because of their own idea of what will be good for them, or because of wholehearted agreement with the relevant members of their family . . . the capacity to take this disintegrative view of oneself without psychiatric prompting seems to be one of the questionable cultural privileges of the upper classes.

(Goffman, 1990, 131-132)

My parents can afford private counselling for me, to prevent being pinballed around an overcrowded public social work system. My medication is covered by their employment plans, and due to a personal connection, I was taken off the waiting list of a top psychiatrist less than a month after my initial request. There is no question that I have upper class privileges that were unavailable to many of my floormates. I'm lucky, and I came into the system with a certain naivety that was never an option for others. I came in with a sense of hope.

You describe the prepatient career as a process where the patient "starts out with relationships and rights, and ends up, at the beginning of his hospital stay, with hardly any of either. The moral aspects of this career, then, typically begin with the experience of abandonment, disloyalty, and embitterment" (Goffman, 1990, 133). There's no question that outside stigma led me to "the big fix" – institutionalization. The moment I thought I couldn't pass anymore, I figured the hospital was the only other place I could

belong. That's why I'm combining my thoughts on "The Moral Career of the Mental Patient" with my observations on *Stigma* (1963). You define the moral aspects of career as "the regular sequence of changes that career entails in the person's self and in his framework of imagery for judging himself and others" (Goffman, 1990, p. 128), which I would rather interpret as the patient judging himself in relation to others – finding a place of belonging within society despite stigma and labelling. I think the moral career of a mental health patient is a long journey to self-acceptance, rather than a "social reworking" (Goffman, 1990, p. 129). My understanding of a moral career as a personal narrative comes from the phenomenological tradition, which suggests that mental illness involves the reduction of a person's authorship over his or her life narrative (Smith, 2006) due to the negative effects of stigmatization.

In *Stigma*, you discuss the necessity of constructing a "stigma-theory," which is "an ideology to explain inferiority and account for the danger [the stigmatized individual] represents, sometimes rationalizing an animosity based on other differences" (Goffman, 1963, p. 5). Autoethnography can then be seen as a counter narrative to stigma-theories, and a corrective form of storytelling that sensitizes audiences to deeper forms of representation. In the previous creative piece, I tried to demonstrate two opposing research methods – participant observation and lived experience – and demonstrate the current power imbalance behind them. Much like my psychology major ex-boyfriend had trouble reconciling his academic perspectives with the realities of mental illness, I often find that you focus on the "awesomeness, distastefulness, and barbarity of a foreign culture" (Goffman, 1990, p. 130) instead of looking for binding threads, thus creating

more social distance between you and your subjects. I think it's fair to say that your description of the moral career of mental health patients suffers as a result.

I don't completely disagree with the concept of a moral career, however much I dislike the name. You hit upon the real journey through stigmatization briefly in "The Characteristics of Total Institutions": "The new recruit frequently starts out with something like the staff's popular misconceptions of the character of the inmates; he comes to find that most of his fellows have all the properties of ordinary, occasionally decent human beings worthy of sympathy and support" (Goffman, 1990, p. 56). Coming from a place of privilege within a stigmatized group, I had to confront the prejudices I held against others in my situation before I could empathize fully with my own struggles. Then, I was able to re-story my illness outside of the medical documentation recorded during my stay. My position as a valued storyteller within the ward later gave me the strength to oppose negative stereotypes about mental illness later on.

In *Stigma* (1963), you suggest that "the stigmatized individual can come to feel that he should be above passing, that if he accepts himself and respects himself he will feel no need to conceal his failing . . . this phase in the moral career is typically described as the final, mature, well-adjusted one" (Goffman, p. 102). The status of my moral career completely hinged on finding a place for myself on the spectrum of mental illness, one where I felt sick enough to belong but still acknowledged the privileges I had been given. I began writing journals – journals which now form the basis of this MRP – about the infinite representations of mental illness that silently existed within me. It wasn't until I published my first story on mental health that I realized where my recovery would lead me. Indeed, you called my next move before I did:

In the case of the mental-hospital patient, this rebirth does sometimes occur, taking the form of a strong belief in the psychiatric perspective, or, briefly at least, a devotion to the social cause of better treatment for mental patients. The moral career of the mental patient has unique interest, however; it can illustrate the possibility that in casting off the raiments of the old self – or in having this cover torn away - the person need not seek a new robe and a new audience before which to cower. Instead he can learn, at least for a time, to practise before all groups the amoral arts of shamelessness. (Goffman, 1990, p. 169)

As a mental health advocate, this “shamelessness” is what appeals to my audience. Lived experience is beginning to take its rightful place beside academic research in the critical discourse surrounding mental illness, and I don’t think my advocacy would be quite as valuable had I not experienced institutionalization as part of my journey.

Young (2009) discusses how authors with mental illness use storytelling in order to build new vocabularies and relationships around their diagnosis, to break the cycle of perpetuated stereotypes and replace them with informed, empowering accounts of trauma and recovery:

The decision to tell one’s story, as part of the plotline of memoirs about mental illness, serves several functions: it allows the writer to represent and affirm a self that, though bruised by mental illness, is characterized by strength and confidence and hope. It gives the writer the opportunity to publicly refute and correct the social construction of mental illness that we all carry in our heads. It allows people to make meaning of their experiences of suffering. And it normalizes many aspects of the experience of mental illness by permitting the writer to

establish parallels between their experiences and the reader's experiences,  
drawing people with mental illness out of exclusion and otherness and into  
interaction with the larger society. (p. 66-67)

Accordingly, the moral career of my hospitalization is not defined by the humiliation that I suffered, or my loss of autonomy – it is the way in which I gained it back, which is perhaps best characterized by this MRP. While I use this paper to reconstruct and re-story my illness, I must keep in mind that its existence challenges many of the preconceived notions that I held before entering the ward, not to mention the ones you drive home repeatedly in *Asylums* (1990). Consequently, my stories must evolve to reflect the moral career upon which I embarked, and they must speak to both creative and critical minds, finding a comfortable place within mental health discourse that challenges stale stereotypes and canonical research methodologies.

Cheers,

- Leanne

## **The Underlife of a Public Institution**

I'd like to make it known that I didn't lose a game of Scrabble the whole time I was inside. This may not sound like much, but once you consider how much Scrabble we played, well, it was pretty much a God-given miracle.

The second night Kevin's chocolate went missing, we called a meeting in the common area. Rob took on the role of lead investigator.

"Have you ever watched Scooby-Doo mysteries?" he asked Kevin's roommate, who was conveniently sporting a chocolate mustache that evening in addition to his fabric arm cast. Slingblade – as we affectionately called him – shook his head no.

"Have you seen this book before?" Rob demanded, shaking a paperback found in Slingblade's drawer that didn't seem to belong there. He couldn't read English. Also, it was definitely Kevin's.

Slingblade sighed, shuffled back to his room, and returned with Kevin's lunchtime chocolate chip cookie. It had a bite the size of a fist missing from it. He sheepishly handed it back to Kevin.

"Are you serious?" he howled.

That night, Slingblade tried to apologize by placing a bedpan of water in the centre of their shared room and chanting around it until 3 a.m. The apology was deemed insufficient by Kevin, who was later sought out by the famed ex-stripper Ro-Ro, who gently offered to provide him with caramel babies. And by gently, I mean she snuck into his room before rounds and whispered into his ear. It was not gentle at all.



Her heightened interest in Kevin could likely be attributed to the fact that he was the only person crafty enough to sneak a cellphone into the ward, which was doubly impressive considering he entered under police custody. After a 176 km/hour drunk joyride down the 401, he had been placed on drugs that mimicked the effects of alcohol (minus the fun, he added). Kevin routinely watched porn at dinnertime, something that made us all vaguely uncomfortable but not enough to threaten our only link with the outside world. His brother snuck us in weed once, but I was too scared to try it on my medication. “How could this place get any worse?” Kevin shrugged, inhaling deeply. I was afraid to find out.

His illegal phone – that’s how Wendy found out her mom died, and how I found out my boyfriend wasn’t coming to see me after all. Pieces of our lives floated through Kevin like a conduit, and to his credit, he didn’t charge us for it – not like we had money or anything. My main form of currency was whatever my parents brought in during visits. I had them bring extra Arby’s for Kevin and Rob, thus cementing our pseudo-alliance as the Three Musketeers. “The least crazy of them all,” maintained Rob, although I wasn’t quite so sure drawing lines in the sand was helping anyone.

I didn’t expect to get my bra back from Wendy after the funeral, but she returned it triumphantly (and a little drunk on dinner wine), along with an itemized list of things I shouldn’t eat if I wanted to keep my youth. That list included eggs, milk, bread, and basically every other food ever invented. “My tits have never looked better,” she purred, throwing her arms around me. The floor had taken a vote and I was deemed best suited to dress Wendy for the outside world, more specifically a world without her mother. I did my best with the meagre contents of my duffel bag, but realized halfway through the

dressing that the best thing I could do in that moment was listen to her reminisce and smile bravely.

The next morning we were allowed into the recreation room – something unavailable to us 23 hours of every day – and I played the piano for the first time since I got sick. We asked the nurses why we couldn't walk the track or play games other than Scrabble without supervision, and they told us it wasn't safe. Being trapped isn't safe, we argued, and so went every conversation we ever had with them. I gave up and sang to Wendy, who was trying to remember her email so we could keep in touch. "I don't have a computer right now, but I will soon," she promised. I had always had a computer, but wondered if I would answer.

When they served pot pie for the third time that week, a fight broke out in the mess hall. Rosemary, the woman who pressed herself against walls when she walked, and Frank, the guy who monitored how many juice boxes everyone took, were both hauled off to the Red Room, behind the door of no return. Manny had come from there, and now he just read Bible verses quietly in his room. I could scarcely imagine a place worse than where I was, but it was enough to know that it existed. The therapy dogs showed up the next day.

There weren't fights over seating or television channels because the people who had been there the longest had that title for a reason, and none of us wanted to risk a Red Room-worthy scene. Instead, we played Pictionary in the hallways and nodded whenever we heard a story for the third time that day. It's easy to run out of things to talk about when you're all doing nothing together. Easy to run out of new words for Scrabble, too.

We missed Frank when he was behind the door of no return – he used to stand by the hallway pay phones like a secretary, running down the halls to find whatever lucky bastard got a call from the outside. I never saw him take one for himself. You could hear snippets of people’s lives through that hallway, even when you tried not to. Wendy’s family, Rob’s mom – when he finally told her – my absent boyfriend, we all wanted them closer and further at the same time. For someone to hold us and tell us it was going to be okay without them actually witnessing what was broken inside of us. It was safer to tell someone who understood, someone whose troubles didn’t seem ripped out of a sitcom.

When we had an audience (of doctors, nurses, or anyone else who could judge us), we were hopelessly self-involved, but when left alone, we reassured each other. We learned about illnesses outside of ourselves, and thanked our lucky stars for what we had (or maybe that was just me). We talked about what we would do once we all got out, how we’d meet for coffee and check in on each other once in a while. The good still seemed too far to touch but you could always see it in other people before you saw it in yourself. I saw it in Rob first, and I’ll never forget the look on his face when I told him.

### **Critical Analysis**

Ervy-Erv,

You probably didn’t get the Fergie reference I made there, but I’ll let it go. Not everyone is as well-versed in the Black-Eyed Peas as they are in sociological linguistics, and that’s okay. Not everyone is quite as familiar with mental illness either, and that’s why we need to have these conversations.

I'd like to start by noting some key differences between your underlife and my underlife. You observe things like Christmas pageants, free outdoor spaces, and ward-run magazines as part of institutional life (Goffman, 1990, p. 95), but those traditions don't exist anymore. This can partially be attributed to the deinstitutionalization movement, which transformed mental hospitals from holding cells to triage centers for psychiatric disorders. The point of Rouge Valley's psych ward was not to get comfortable, but to move as quickly through the system as possible to avoid overload. Still, consumption of neutral spaces was the most freedom we could earn, alongside harbouring our personal belongings. As you observe in "The Underlife of a Public Institution":

In everyday life, legitimate possessions employed in primary adjustments are typically stored . . . in special places of safekeeping which can be gotten to at will . . . More important, these places can represent an extension of the self and its autonomy, becoming more important as the individual foregoes other repositories of selfhood. If nothing can be kept only for oneself, and everything one uses is used by others, too, then little protection from social contamination by others is possible. (Goffman, 1990, p. 248)

I agree that objects became souvenirs of our lost personhood, but instead of social contamination, these objects, when shared, became a way for elevating social status in the new world we created for ourselves. If objects were equated with increased privilege, it only makes sense that – similar to humanitarian aid in the outside world – there was something to be gained by the giver when shared. This could perhaps emerge through a regained sense of community or positive self-assurance, or even just the simple pleasure of playing a role in a contained society. Helping Wendy is one of my fondest memories

of the ward, mostly because it reminded me of home, and how I often lent my closet out to friends for big events. Recreating my social function within the ward was important to me in a way that overrode my initial urge to maintain social distance.

As Babb (2014) states, “pluralism [within mental health discourse] allows outcome behaviours to be explored to offer explanation, rather than labelled as “wrong” or “intolerable” (p. 12). I think that there are two ways of looking at the issue – the way you did, that “mental patients by definition are incapable of sustaining ordinary order and solidarity” (Goffman, 1990, p. 302), or that we were doing the best we could to make do – with free spaces, with group territory, with each other. Emphasizing the otherness of our situation doesn’t change the fact that we were a community – of outsiders, maybe – but still functioning community.

These community bonds lead to underground information systems and almost a black market-like trade of goods and services – however, the currency required to participate in this sort of social system is not money but a certain mutual sympathy. As you point out in *Asylums* (1990), “inmates privately related loaned each other money, cigarettes, clothing, and paper-back books they helped each other move from one ward to another; they brought each other mildly contraband materials from outside the hospital . . . and they listened to each other's exposition of his case” (Goffman, p. 279). The best quality to find in a fellow patient would be that of a good listener, someone who validated your journey towards recovery. Inside a psychiatric ward, the outsiders are not necessarily the lowest on a sliding scale of mental competence, but the ones who oppose the recovery interests of the group. Anyone willing to contribute to the creation of a supportive community is appreciated to some extent.

In “The Underlife of a Public Institution,” you maintain that the number one priority of inmates taking part in the underlife is to “place a barrier between the individual and the social unit in which he is supposed to be participating . . . a self-preserving rejection of one’s rejecters” (Goffman, 1990, p. 315). However, I do not believe that this barrier extends to the social life of the ward, as patients receive the most validation from each other rather than the system. Interactions as equals, instead of medical specimens, become essential to the preservation of patients’ humanity. As you observed, it was a delicate balance to maintain: “Our sense of being a person can come from being drawn into a wider social unit; our sense of selfhood can arise through the little ways in which we resist the pull. Our status is backed by the solid buildings of the world, while our sense of personal identity often resides in the cracks” (Goffman, 1990, p. 320). I think that maintaining friendships against the hospital’s best attempts to discourage them became an act of defiance too – that we could still laugh and bond even though half of us wanted to die was nothing short of amazing. And that’s what brought us together.

I love the quote you included from Milosz’ *The Captive Mind*: “Internal revolt is sometimes essential to spiritual health, and can create a particular form of happiness. What can be said openly is often much less interesting than the emotional magic of defending one’s private sanctuary” (Goffman, 1990, p. 320). My floormates became crucial parts of my emotional sanctuary, and as we defended each other against the sterilizing nature of the institution, we started to feel like people and not science experiments again. We became a community and rooted for each other when we took our meds, or told a loved one where we were, or even when we prevented theft that one time.

You can put our behaviour into sociological boxes, but the underlying instinct is still survival. I agree with Creswell and Hawn (2012) that sometimes your findings tend to “treat realities as resources that can be rhetorically manipulated” (p. 2). While I believe stigma is socially constructed, to socially construct mental illness is to ignore its medical realities. As Siegler and Osmond observe, there is a difference between autonomy for people with mental illness and placing blame on them for not meeting social expectations due to something they can’t control:

What the conspiratorial writers do not see is that the patients are truly ill, and that it is not helpful to them to tell them that their illness, which is very real to them, is a social fiction, just as it would not be helpful to tell a victim of cancer that cancer is “just a label.” The solution for those with psychiatric illnesses lies in the opposite direction: they need to be given and sustained in the sick role. (Siegler and Osmond, 1971, p. 423).

The conventional sick role still involves elements of patient opinion and participation – what is needed for the psychiatric sick role is an emphasis on the importance of personhood in the medical model, and the removal of stigma from inside the psychiatric system.

X’s & O’s,

-- Leanne

## **The Medical Model and Mental Hospitalization**

I woke up that night in a cold sweat, not recognizing the white walls around me nor the smell of disinfectant in the air.

It was the end of my first week in the ward, and doubts were starting to creep in. The cheeriness with which I had committed myself had faded, along with the optimism of my doctor – whom I only saw once a day, for approximately ten minutes (not that he was timing it, but he might as well have been).

When I asked what the difference was between me being there and me being home, he frowned first, he offered a single word: titration. I took chemistry in high school and understood the basic meaning behind the phrase – that by visiting me for ten minutes a day, he'd be able to consistently track the effectiveness of my medication and adjust it accordingly. The problem was, I didn't buy into it anymore.

My breath felt tight in my throat, every insecurity and suicidal thought pressing into my neck like barbed wire. If this was my last hope – a place with so little hope – what would the next ten years of my life look like? Would I even make it past the first three? My body began to shake uncontrollably, sobs racking my lungs and tears streaming down my face. I hadn't cried since I arrived.

I slipped out of my room and tiptoed down the hall towards Rob's room. I knew I wasn't allowed in there but I couldn't let a nurse see me like this – any progress I had made would be immediately erased. He only started a little when I tugged on his shoulder.

“Jesus, Leanne! What's wrong?”



I buried my face into him. “I think I’m starting to break a little,” I said between sniffles. He wrapped his arms around me and held tight.

“Hell, you lasted longer than the rest of us.”

We sat silently as my tears subsided, looking thoughtfully out the window overlooking a drive-thru Wendy’s.

“When we get out,” he said, “We’re going to dress up. And we’re going to have a nice meal there.”

“At Wendy’s?”

“It’s better than pot pie.”

It was true. Everything is better than pot pie.

“You know, I didn’t know you ever felt like me,” he continued. “You’re always so put together that I almost forgot you were sick.”

I grinned. “Good. I’m trying my best to forget myself.”

“It’s okay to feel like that, you know. Not put together. Falling apart – whatever it takes to get to the root of it. Even being here when you’re not sure why, that’s okay too.”

I didn’t realize that I needed as much validation as the guy who thought he was Jesus, but I did. I needed to know that I belonged here, that what had happened to me wasn’t weakness but genetic circumstance coupled with environmental factors, that there was a name and a community that I could claim as my own. There’s no one way to the ward, but there’s several ways out of it. This was mine.

“What are you two doing?”

Elaine, the nurse whose spirit animal was in all likelihood a toad, was standing in the doorway of Rob’s room. She grabbed my arm and hauled me into the hallway.

“I’m sorry, I just needed to talk to someone. I was so upset, and felt like I was losing control of my body, so I—”

“The hospital is not a dating pool,” she hissed.

I stopped walking and stared at her.

“That’s what you think I’m doing? Everything that goes on here and you’re worried about that?” My voice got louder and Rosemarie started screaming. “I just needed to *talk* to someone!”

A second nurse came out of the woodworks, tranquilizers in hand.

“No! You can’t just tranquilize people every time they’re struggling – that’s not fair. You’re not solving the problem. Why can’t you just talk to us?”

And then I was tranquilized.

When I woke up the next morning – feeling more or less like roadkill – my doctor was already sitting in my room.

“Well, Leanne,” he said brightly, “It looks like you get to go home today!”

I stared at the doctor like he was wearing a sombrero. “What?”

“You’re all cleared to leave,” he said in his perfect Morgan Freeman voice. He brusquely scribbled some doctor stuff into my file and peered at me over his clipboard. “You look a bit confused.”

Resisting the urge to table-flip my meds, I exhaled slowly. “Why is this a thing that is happening today?” I asked, so very articulately.

“Do you not want to go home?” he replied. His eyebrows arched like a comic book villain.

Don’t get me wrong – I totally did. Despite the always-entertaining game of “what-else-can-they-make-into -a-pot-pie?” I was ready to leave, and not for the obvious reasons. While lunchtime conversations could segue from “how about ‘em Leafs?” to “my boyfriend is the antichrist and used his radioactive stare to bore cancerous holes into my leg” without a change in ambience, I wasn’t afraid anymore. The key to surviving was a silent acceptance that each person’s story was true in some reality or another. We were all fighting the same invisible monsters – mental illness, but also occasionally the hospital itself.

“I was planning on going home when I felt better,” I said, “And I’m nowhere near better. Last night –”

“I’ve already heard about last night,” he said shortly. I realized exactly what was happening. “Don’t tell me how to do my job.”

I didn’t say goodbye to everyone because I knew from the patient grapevine that I would see them all in day treatment – escaping the clutches of Rouge Valley was a

graduated system. I hugged Wendy, awkwardly fist bumped Kevin, and stood with Rob by the exit (under the watchful eyes of the nurses' station).

"Hug me and see if they flip out," I said.

"Uh, you're not the one that has to stay here," he said. He hugged me anyway.

"See you on the outside."

But I didn't – at least not for a while. My doctor, considering the less than civil manner of my discharge, did not enter me into a hospital recovery program. Rob and Kevin went, until Kevin got sent to jail and Rob met the love of his life in there. Treatment, not jail – although anything is possible. Two months later, I wound up on the edge of a highway overpass, but chose not to return to the ward. I didn't think I could let it break my heart twice.

### **Critical Analysis**

To Erving the Great,

I think I might have better reasons to hate institutions than you. Although I'm starting to think my bias is just as bad as – if not worse than – yours was. Shalin (2014) states that "while having first-hand, personal experience with mental illness sensitizes the investigator to the subterranean dimensions of phenomena in question and opens new horizons for research, it can also blind the interpreter to dynamics inconsistent with the specific case in which one is intimately involved, foreclose additional avenues for research, and make the over-engaged scholar partial to conclusions reflecting his or her bias" (p. 137). At the same time, I don't know if impartiality really matters to my MRP, at least not if the point is to determine a better position for the patient narrative. The real

objective is to place it on an equal platform with outsider perspectives like yours, and allow for a more fully-rounded critical discussion of psychiatric systems.

Psychiatry, as you define it, is a field in which “social misconduct and visible organic pathology are brought together in a perfect confirmation of the applicability of the medical model” (Goffman, 1990, p. 352). However, as most cases emerge out of reports of social misconduct, it is difficult to pinpoint to what extent these illnesses should be treated – there is a distinct crossover between propriety and pathology that often results in measures of social control instead of medical care. As you put it so eloquently, “instead of a server and the served, we find a governor and the governed” (Goffman, 1990, p. 353). It is a strange dynamic not found in physical illnesses, which do not take into account emotional, environmental factors. The ward acts as a vacuum chamber in which, hypothetically, the broken bits can be removed. Drawing a distinction between physical and mental illnesses (while the brain is part of the anatomy) undermines the credibility of the patient and the diagnosis. Symptoms are instead reframed as behaviors that heavily rely on social transgressions rather than medical incidents.

Diagnostic decisions, in turn, can be decided based on the clinician’s personal ethnography instead of a strict set of objective measures. What is acceptable and unacceptable to the server is then translated into the patient’s diagnosis as you so aptly describe:

According to the common-sense definition, mental health is the ability to play whatever the game of social living might consist of and play it well. Conversely, to refuse to play, or to play badly, means that the person is mentally ill. The

question may now be raised as to what are the difference, if any, between social non-conformity (or deviation) and mental illness . . . [it] does not necessary lie in any observable *facts* to which they point, but may consist only of a difference in our *attitudes* towards the subject. . . should we feel, however, that we cannot communicate with him, that he is somehow "basically" different from us, we shall then be inclined to consider him no longer as an equal but rather as an inferior person; and we then speak of him as being crazy. (Goffman, 1990, p. 364-365)

While I believe that diagnoses can be affected by ethnocentrism, to frame mental illness solely as social misconduct is to ignore the biological factors surrounding it. You point out the conflict yourself: "In psychiatry there is a formal effort to act as if the issue is treatment, not moral judgement, but this is not consistently maintained" (Goffman, 1990, p. 365). This inconsistency is extended to the social constructivism of mental illness, which alternates between scapegoating and diagnosing people with mental illness. Without experts coming to a common consensus over mental illness' place in the medical spectrum, it is impossible for patients to receive effective treatment or maintain a firm grip on their own narratives within the larger scope of academic discourse.

While you argue that "current official psychiatric treatment for functional disorders does not, in itself, provide a probability of success great enough to easily justify the practice of institutional psychiatry as an expert service occupation, as here defined, especially because the probability that hospitalization will damage the life chances of the individual is, as already suggested, positive and high" (Goffman, 1990, p. 362), I think that if hospitals are not treated as holding cells, but as incubation chambers, releasing patients slowly into everyday stressors, there is hope. Admittedly, there is a push towards

more integrated mental health recovery centres that encourage autonomy and self-care as equally important as prescriptions, and maybe that's part of the answer. Maybe it's time to acknowledge the complex social and medical overlap of mental illness, and try to treat both sources.

If we support Babb's (2014) notion that we must oppose "the faction of the state to label and act based on power, social discrimination, and fear, since it . . . organizes and activates the societal reaction" (p. 15), then perhaps sociological dissections of mental illness actually serve to harm mental patients, rather than support their undervalued perspectives. The further mental illness gets from its medical roots, the more it can be framed as a personal weakness. In terms of future academic research, the study of stigma seems like a far more compelling subject in the field of sociology, instead of hypothesizing over why people get sick – they get sick because their brains work differently, not because they're deviant.

Until next time,

-- Leanne

## Conclusions

Dearest Erving,

You'll be happy to know that the train didn't stop with *Asylums* (1990). In 2013, Adlam et al. published a collection of essays entitled "Perspectives on Erving Goffman's 'Asylums' Fifty Years On," which incorporated the critical perspectives of several mental health experts – including psychiatrists, psychotherapists, a philosopher and a medical graduate student – yet still without creating space for the fundamental perspective of psychiatric lived experience. As one essay argues, *Asylums* was "a major impetus to the whole deinstitutionalisation movement and, certainly, the role of public opinion, inspired by Goffman as well as *One Flew Over the Cuckoo's Nest*, should not be underestimated" (Adlam et al, 2013, pp. 612). While steps have been made towards encompassing stories of mental illness into everyday life, there remains a methodological othering of autoethnography within its field of mental health experts. This exclusion of mental illness as a cultural experience demonstrates lasting stigma within research methods, stigma that is preventing a full-fledged look into mental illness. Adlam et al. (2013) complain that from your perspective, the patient "is treated as an object of study, an instance of some disorder, rather than as a subject in her own right" (pp. 609), but continue to objectify mental patients by excluding their perspectives in a historical review of their circumstances.

Funnily enough, the power of lived experience comes through your later work, in "The Insanity of Place" (1969). We both know I'm not your biggest fan as a sociologist – I think you often place sociological health in front of mental health, and it's a perspective that dehumanizes your participants – but I definitely empathize with and respect you as a



caregiver. Your wife was diagnosed with bipolar disorder, which is what I have. You did everything you could with the knowledge you had, and she jumped off a bridge despite your best efforts<sup>2</sup>. And you did what any good researcher would do – you tried to write about it, tried to teach others about the devastating effects of mania and depression. What good is our pain anyway, unless we can turn it into something constructive?

“The Insanity of Place” begins with a reiteration of *Asylums*’ skeptical tone towards psychiatric care: “[Mental health] patients recover more often than not, at least temporarily, but this seems in spite of the mental hospital, not because of it. Upon examination, many of these establishments have proven to be hopeless storage dumps trimmed in psychiatric paper” (Goffman, pp. 357). However, the path changes when biology is brought into play: “But what is not seen – and what will be argued in this paper – is that biological norms and social norms are quite different things, and that ways of analyzing deviations from one cannot be easily employed in examining deviations from the other” (Goffman, 1969, pp. 363). Gone are the quotation marks around mental illness, and gone is the rampant dismissal of the organic factors that have been proven time and time again to be deeply connection to mental disorders. Instead, the constructivist viewpoint is replaced by a fixation on mental illness and havoc, likely due to your own experiences. Not quite autoethnography (you don’t openly admit it, anyway), but the writing begins to take on a tone of lived experience (also, sheer exhaustion):

In the case of incurable disorders that are messy or severely incapacitating, the compensative work required by the well members [of the family] may cost them

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2 Goffman’s wife, Angelica Schuyler Goffman, committed suicide during the summer of 1964. She had a record of manic-depressive illness and had previously been hospitalized.

the life chances their peers enjoy, blunt their personal careers, paint their lives with tragedy, and turn all their feelings to bitterness. (Goffman, 1969, pp. 367).

Of course, your wife was feeling pretty bitter too. In a 1963 letter, she vents about the symptoms of her illness and then adds, “I know one isn’t supposed to say these things – especially if in any way affiliated with one E. Goffman” (Shalin, 2013, pp. 129).

Perhaps your initial distaste for the psychiatric field and your tendency to discount people with mental illness as “faulty actors” made you unapproachable, and it changed the way you understood and wrote about mental illness. “The Insanity of Place” was released a few years after your wife’s death, and while you never mention her within the piece, the writing seems to come from a different place – a place of passion, of your own lived experience. And while some people might not have sympathy for you<sup>3</sup>, I do. You might have written about mental illness as a sociological phenomenon, but to you it was pain:

The [sick] individual’s failure to enact through deeds and expressive cues, a *workable* definition of himself, which closely enmeshed others can accord him through the regard they show his person, is to block and trip up and threaten them in every movement that they make. The selves that had been the reciprocals of his are undermined. And that which should not have been able to change – the character of a loved one lived with – appears to be changing fundamentally and for the worse before their eyes. In ceasing to know the sick person, they cease to

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3 “Well of course everybody thought that Goffman had driven her to suicide because he was such a bastard. I mean, that was the gist of what people had to say. It was like, “Anyone who had to live with him would jump off the bridge” (Shalin, 2013, pp. 137).

be sure of themselves. In ceasing to be sure of themselves, they can even cease to be sure of their way of knowing. (Goffman, 1969, pp. 374).

I'm glad that you had begun to come to terms with other ways of knowing – including autoethnography, however unofficial – but at what cost? Cognitive dissonance, perhaps, and the greatest loss of your entire career. If you're still reading this (aka the longest letter anyone's ever written to a deceased sociologist), I hope that you've found peace with your methodology, your family, and your legacy.

Sincerely,

- Leanne

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