Class Aspiration, Diaspora, and Dis-ease with the 'Neurasthenic' Condition:

Feminist Sense-making Through an Institutional Autoethnography of OCD Discourse

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In the following paper I focus on how an institutional autoethnography of my experiences with the diagnosis of OCD demonstrates the potential for using memory work and everyday encounters as a way to initiate conscious-raising about areas for social change necessary to challenging psychiatric oppression. I am not here to perform a pop cultural study or social movement critique of Mad identity tropes. Scholars such as Emily Martin (2007) have begun to pursue these research interests through studying, for example, the homogenous mythicization of mania as achievable, idealized hyperproductivity. Rather, by presenting a substantive critique of the diagnostic processes I have experienced, I identify psy capitalist and imperial webs of institutional relations. Autoethnography, beyond (and yet reliant upon) "just telling a life" (Flemons and Green, 2002), begs us to question the material-structural short-circuits in our interpretation of what we perceive as a "singular" narrative in any given moment.

I am concerned with studying what ideologically and materially mediates how we make sense of embodied "madness". I use madness to loosely refer to altered states of consciousness – to different beliefs/feelings/needs/behaviours that are pathologized by psychiatry.

The term "sense-making" is something I use throughout my thesis to capture both available paradigms for rationalizing madness and alternative, self-determined ways of understanding and living with "madness". For example, one available paradigm in psychiatry posits that obsessive thoughts are irrational and arbitrary, should not be analyzed, and should be removed (Penzel, 2000). An alternate understanding that resists dominant models would be Mitchell-Brody's from *The Icarus Project*. She says "There is much in our world to be angry, anxious, and sad about" (Mitchell-Brody, 2007, p. 143). Her view is that people diagnosed with depression are actually an indicator species in humanity, showing us how our society is unhealthy as a whole. Madness here is understood as useful knowledge for directing social change. These dominant and alternate approaches to understanding sense-making co-constitute and inform one another. They are distinguished from each other merely as an analytical tool, the former underscoring subjectivity (discourse) and the later centering on agency (identity).

Understanding 'OCD' through institutional autoethnography

Compelled by my own history of being psychiatrized broadly speaking, I used autoethnography as a research method for my undergraduate thesis from 2009 to 2010. Autoethnography takes your own life experiences as data for shifting from your particular location to some universal understanding of a research question. Focusing mainly on a period of crisis I had in 2008, I employed an institutional analysis of my own patient records to reflect about a confluence of narratives that produce Mad knowledge of what I refer to as *morbid thoughts and compelling needs*. The following is an example of how autoethnography and institutional ethnography may be merged through institutional autoethnography:

Eugenicist and Enlightenment ideas have descended transgenerationally in my family through our colonized history in China, whereby class mobility continues to be conflated with finessing the healthy body. In a sophisticated personal genealogy, I can locate paper sources such as my father's school documents in order to study education as a hegemonic institution. These forms of data reveal how sanist notions of 'the good body' are discursively produced through bourgeois Protestant and Catholic missionary schools in Shanghai and Hong Kong, which continue to hold ideological power over the education of Chinese youth today.

And so, I look at psy experiences in my life and juxtapose them against my own "feeling out" of who I am and what my body does, attempting to address the epistemic gaps in my helpers'

logic. Of the several diagnoses I have from the mental health system, Obsessive-Compulsive Disorder remains the most insidious label. My purpose is to demonstrate how systems of colonial domination, racialization and economic exploitation are operationalized through the medicalization of certain patterns in habit and certain affects of stress. I want to provide alternate knowledge about the kinds of embodied, qualitative experiences like those haphazardly captured and twisted by the category of OCD.

There is little to no research by psychiatric survivors that critically challenges OCD discourse. Most alternative work that expresses new ways of understanding madness focuses on depression, on what is called 'borderline personality disorder', on 'auditory hallucinations' or hearing voices, and on 'schizophrenia' or unusual beliefs (Kali, 2009; Klafki, 2007; Knight, 2009; Lafrance, 2009; May, 2007). There has also been a risk of romanticizing madness as genius or creativity and giftedness. However, the literature produced by decades of user, ex-user, survivor and Mad people's insights and testimonies is central to my own analysis of OCD.

I contend the 'madness cum oppression' thesis (Burstow, 2005; Klafki, 2007; Mitchell-Brody, 2007) is a heuristic device for calling attention to how phenomenological knowledge that is not institutionally tested is devalued. That the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is articulated by a body of knowledge-makers who are not themselves located as having lived experiences with the phenomena described exposes the disembodied ("I"-less) nature of such a text. In the *DSM-IV*'s section on Obsessive-Compulsive Disorder, 300.3 (an anxiety disorder), the holistic nature of my research is juxtaposed against the understanding that:

> The thoughts, impulses, or images [of obsessions] are not simply excessive worries about real-life problems (e.g., concerns about current ongoing difficulties in life, such as financial, work, or school problems) and are unlikely to be related to a real-life problem. (p. 418).

My sense-making challenges the manufactured disconnect between 'obsessions', 'compulsions', and real-life problems. It is no felicitous accident that such sense-making, if shared with my GP, would grant me the additional specifier of "with poor insight": "applied when, for most of the time during the current episode, the individual does not recognize that the obsessions or compulsions are excessive or unreasonable" (*DSM-IV*, p. 419). Radical, alternative articulations of madness that view unusual beliefs/behaviours as 'rational' responses to oppressive social conditions do not cohere to the parameters set by the *DSM*. Instead, new insights translate to a lack of insight.

A curious exemption to a diagnosis of obsessions is provided under the subheading "Specific Culture, Age and Gender Features", where "[i]mportant life transitions and mourning may lead to an intensification of ritual behavior that may appear to be an obsession to a clinician who is not familiar with the cultural context" (*DSM-IV*, p. 420). As I demonstrate in the final section of this paper (see "Embodying psychic stress"), neither my GP nor my SW (social worker) try to contextualize my "culture" beyond the potential racist assumptions made by my physician. If this basic practice is neglected by practitioners, does that not render the diagnosis of obsession completely contradictory? The language of cultural context itself must also be challenged, as it risks reifying culture as having homogenous and primordial properties. Professional helpers who fail to recognize context are doubly problematic should they substitute reductionism for a relational critique.

A feminist research methodology

I apply concepts such as "feminist standpoint", "historical materialism" and "ruling relations" in my work. These frameworks are what structure my project as specifically feminist, insofar as unspeakable forms of knowledge are placed at the center of my work as valuable resources. Hartsock (1998) has stated that experience under patriarchy allows us to understand as women the falseness of such a view and for us to have an understanding that is more complex than such a view (p. 242). This is the spirit of standpoint – that our situated, located selves carry marginalized knowledge that is rich and needed to fuel social change. It embraces materialism in that our experiences are critically taken as reflecting the larger relations of our world. I use standpoint to explore how my complex situatedness as powerful/powerless (as Asian Canadian, as middle-class, as a person in higher education, as diagnosed with so-called 'mental illness', as a sexual menace) reveals the falseness of psy/madness discourses I have faced.

In my analysis to follow, I refer to moments I deconstruct in my autoethnographic analysis as locally universal moments, to use Mohanty's (2003) language. Her use of local to universal has emphasized how our material life structures in the everyday world can be traced to larger transnational economic systems and policies (p. 504). In my historical materialist approach to reflecting on memories and assessing texts, I prioritize the view that change occurs in society not merely through ideologies, but the actual production of things and movement of people. So beyond just expressing myself, what do I need to "live" – to live as a "Mad" person who is also racialized, who is disadvantaged as a woman, who is left out as queer? This quasi Marxist approach will blend and integrate physical, economic realities into ideas about social behaviour and action (like those of people in my "story").

Smith (1994) argues power is textually mediated. She takes Foucault's notion of knowledge-power and makes it very tangible, emphasizing the power in text for regulating our lives – relations of ruling. I use this take on political economy to complement my historical materialist approach to researching the issue of choice in "Mad" sense-making. I.e. *making sense of psy-like/Mad experiences is bound by certain administrative, "paper" things we can touch around us*. The above theoretical approaches underscore my feminist focus on social constructivism and knowledge production. In the act of critical memory work, I refuse to take at face-value the myriad truths that have sculpted my experience. I am taking apart the (psychopathology, "illness") discourses and tracking them in tangible objects around me and in my past.
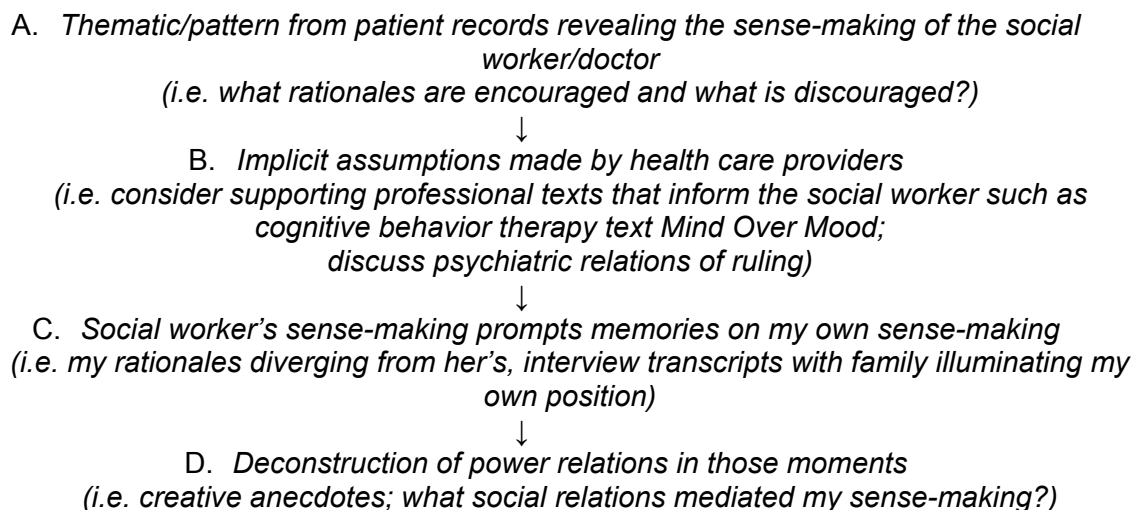
FIGURE 1: Analytical structure of my thesis as a whole

> A. *Thematic/pattern from patient records revealing the sense-making of the social worker/doctor*
> *(i.e. what rationales are encouraged and what is discouraged?)*
> ↓
> B. *Implicit assumptions made by health care providers*
> *(i.e. consider supporting professional texts that inform the social worker such as cognitive behavior therapy text Mind Over Mood;*
> *discuss psychiatric relations of ruling)*
> ↓
> C. *Social worker's sense-making prompts memories on my own sense-making*
> *(i.e. my rationales diverging from her's, interview transcripts with family illuminating my own position)*
> ↓
> D. *Deconstruction of power relations in those moments*
> *(i.e. creative anecdotes; what social relations mediated my sense-making?)*

FIGURE 2: Specific foci for coding constraints and facilitators to sense-making

Individual or institutional analysis of wellbeing?	Is the text suggesting "individuals are responsible for their own health, success and prosperity" or is there recognition of structural oppression as a social determinant of health, ex. law (Lafrance, 2009, p. 112)?
Neoliberal and capitalocentric paradigms	How are the goals for a patient's understanding of their "illness" reflective of political economy (in what way is mad sense-making embraced by clinicians?)?
Relationality in identity	Are nuanced patient narratives included in the discussion that explores our multi-faceted coproduced subjectivities (i.e. race, class, gender)?
Holism/universalism in recovery	Is madness understood as a "socially significant sign" where strategies for wellness require "outside" shifts (Deana Kanagasingam, personal communication, January 27, 2010)? Or is distress located "inside" the body via biomedicine and symptomatically treated?

The remainder of this paper contains excerpts of my creative prose focusing on habits and routines I practiced growing up, during which my body was disciplined for fear of cultural mixedness, class delinquency and sexual transgressions. The interpersonal tensions shared in my memory work are reflected and refracted through my closing institutional critique of neurasthenia and 'obsessional neuroses'.

Excessive feelings harm you

Sybille sits with me in her suburban office out at Southlake. It is 2003. Her office is in a child and family clinic, bearing the usual aesthetic (ambient lighting, slightly out of date office furniture from the early 1990s upholstered in muted abstract shapes).

Before the terror of my imagination and before cutlery was menacing, I worked with Sybille on my habits and routines and the particular ways I would arrange my sacred spaces – the margins of my high school notebooks; the symmetrical placement of objects across surfaces of my seven foot long wood desk, bedside table, shelves, closets. We were both trying to find some optimal way of being without a laborious sense of overwrought consumption in my routines, recognizing the unequivocal solace and beauty of an orderly space, but also observing the disruption and dissonance it incurred in my relationships and school life.

It (therapy, medical attention) has never been anything but a fine-tuning of my ability to thrive as a student – a productive student. The single most honest observation she did offer that day was transparency about the ambiguity in the obsessive-compulsive spectrum of diagnosable behaviours. Which acts reign in the realm of "character" and which acts are compulsive?

Her genuine recognition of the arbitrariness of the diagnosis falling on those who are consumed with their thoughts and habits for more than an hour for every twenty-four contributed to my present pragmatism and holistic attitude towards living "mad". If only she had entertained the practice of understanding why I labored so hard for a pristine work space, for a uniform sanctimonious script. What pained me so deeply that I tried to exert self-control through the materiality of everyday objects around me?

The failures in her use of behavior modification, I noticed, were partly attributed to its very reliance on the values of schooling – on discipline. In spite of my disorderliness (or was it hyperorderliness?), in spite of my 'disease', we planned homework assignments on modifying my habits much in the same meticulous manner I would try to perfect page after page of my handwritten notes. These tasks escaped me, and you learn quickly the useful artifice of a white lie in therapy. Ironically, in "acting" the role of a recovering patient, I was able to obtain the listener and companionship I griped for at thirteen, fourteen, and fifteen…

My whole soul shook with the need to express anything about my being in certain spaces: My father, harming me for my own Good… then the tender perfection of my work, my molecular models, my posters on taxonomic groups for high school biology. Folding paper, writing, drawing. Slowly, so slowly. A muted stillness, survival. The painstaking look of effortless beauty to glare in the face of daddy's dogma. Even now, my penmanship remains something of a masochistic enterprise, a fanciful practice tempered and accepted in moderate quantities. No misgivings in light of other preoccupations of my twisted imagination.

Relationships make us

My father punished me for any kind of sexual behavior throughout my high school years. The vacuum cleaner. I heard it, the loud insufferable noise. My room, an archeological dig. Flipping, flipping, flippant. His words: "This is for your own good".

Anaïs Nin, fuckable feet, and latex-clad purple-haired hentai girls. Self-pleasure placed me as a "hooker", "corrupt", and "immoral". My parents, sure that my sexuality made me untrustworthy and disloyal, were wholly convinced that the abrupt end of a significant relationship in my teens, with a friend I once called my "Secret Agent Lover Manzz", was caused by my "easy" nature.

If I was incapable of vowing all sexual intimacy to "my future husband", I was incapable of being disciplined at all. Given my mother's Protestant upbringing in a mixed-classed district of Hong Kong (affluent in the high-rises, desolate on the ground) and my father's dogma housed beyond the doors of his "advanced" British-run grammar school, it is no revelation that piousness, liberal careerism and scientific thinking became their Holy Trinity of reason.

From filtering over a decade of stories about his days as a school boy (as long as I could remember), the selection of his English name (was it from a dictionary or a Bible? No, he was named after a Father who taught with an iron fist), his baptism – I know that my father's education is rapt in the principles of the Salesians missionary organization from Italy. Salesians was founded on the premise of helping youth around the world cope with the industrial revolution. To this day, its schools in China are based on a model of developing their students' competency as "contributing members of society" (Salesians Missions Online, 2010).

What is "Chinese" about their parenting is a hybridizing of the conservative, capitalist values of free-trade Hong Kong with a Catholic colonial legacy. My father belonged to a diaspora of young educated Hong Kongers fleeing en masse before the handover, in the hopes of flourishing and strategically assimilating into the Western world for self-fulfillment. As soon as my father received a full scholarship from McGill University, he left, out from humid Wan Chai and into the bone-chilling whiteness of Montreal.

Embodying psychic stress: Diagnostic alterations to sense-making through physical symptoms

The previous italicized narratives are my attempt at initiating a process of identifying transgenerational mediators to mad sense-making that are postcolonial and liberal individualistic, in particular the migrant struggles exerted upon generation after generation of a diaspora. Family forces in altering an epistemology of "OCD". These introspective, fragmented passages are also an attempt to reveal how a feminist aesthetic of self-reflexivity on my own subjectivity greatly affects my sense-making today, allowing me to identify trends in my rationalizing process throughout my adolescence and parts of my adulthood.

The material-relational nature of my analysis identifies how resource abundance and peer support through communities such as the Mad movement have a profound impact on allowing me to make sense of my morbid thoughts alongside a body of sense-makers articulating against mainstream medicine. This raises the transformative sense-making possibilities of "Mad" consciousness-raising in community development.

I am diagnosed with hysteria and neurasthenia during my adult crisis with morbid thoughts in 2008 – aggressive and graphic thoughts of harm towards myself and loved ones. These terms, though not widely used in psychiatry today, are still ascribed to by some healthcare professionals. They are diagnoses seen in my medical records from my family physician, potentially made common knowledge with the North York Family Health Team. Psychophysical symptoms are consistently described throughout my physician (GP) and social worker's (SW) case notes: "she describes the physical sensation [of panic attacks] as being 'shaky', but feels it's more cognitive"; "*Louise cried throughout the session." (social worker's initial assessment, June 6, 2008). These physical sensations are considered unusual, particularly emotional and problematic through their verifiable alignment with current (and "out of date") psychiatric diagnoses, specifically ones categorized as "neuroses" (physician's report, February 28, 2008).

To my knowledge, these are psychopathologies that do not involve "a loss of touch with reality" (or as I like to understand it: an alternate reality distinguishable from those around you), but show distressed signs of 'maladjustment' to your work environment or living situation. "Hysteria" and "neurasthenia", terms that have a common history, I will explore circa 1880-1930, *make sense* of stress, irritability, exhaustion, and other physical-cum-psychological symptoms as a marked, inferior weakness, a nervous condition (Kleinman, 1986). Neurasthenia's popularization in the early twentieth century by Japanese and American medical culture (including names such as Japanese psychiatrist Shoma Morita, 1922) has even seen it described as "obsessional neuroses", colliding and colluding with qualitative experiences traditionally marked as "obsessive-compulsive", such as "perfectionism" and overachievement to the point of burnout and "obsessive self-consciousness" (Kleinman, 1986, p. 25).

Popular consensus by the disenchanted public tells us that women are diagnostically more prone to being labeled with nervousness, worry and unexplainable feelings in a heteropatriarchal world that revolves around a masculinist, capitalist work ethic. Depression, hysteria and anxiety states now replace the use of the term "neurasthenia" in North America in the last century, but "neurasthenia" remains a prominent diagnosis in other countries where distress in the body is a readily accepted paradigm rather than mental disorder, in particular China (Kleinman, 1986). Given the approximate age of my GP, who is in her mid-forties, it is uncertain whether or not she was in medical school at the time the *DSM-II* was still in use, as the *DSM-III* was published in 1980 (by then neurasthenia was removed from the manual on the grounds of it denying a "proper" psychiatric diagnosis).

I can only hypothesize my GP's rationale when she entered "neurasthenia" into my files. Was her medical training somehow exposing her to an anachronistic diagnosis that was dropped

from Western psychiatry since the 1980s? Did she never update her knowledge about shifts in psychiatry and contemporary practices? Is neurasthenia still commonly used by my GP for burnt-out patients working stressful sedentary careers? Or, based on the culture-bound syndromes documented in the *DSM-III* and *DSM-III-TR* since then, was her categorization of my "neurosis" determined by my readability as Chinese?

The notion of reclaiming our animality and the visceral physicality of our bodies as we respond to our environments is crucial. It is possible that "illnesses" that make visible the affects of stress on our material bodies draws attention to serious distress that must be addressed and incorporated into a rich and complex view of "madness". What we need to question is how this distress is framed – as sickness to be treated in the individual or as a sign of an unhealthy society. Unfortunately, "psychosomatic" or "somatoform" disorders potentially operate as a device in my case for: (1) racializing and feminizing my body (evident when historicizing the use of these diagnostic categories, where I find neurasthenia was adopted by China as an acceptable reference to workers' burnout) and (2) biologizing (reducing my stress to a physical illness that requires no broader questioning and accountability).

I argue that her rationalizing of my anxiety as neurasthenic is through (1) the failure of my case to conform completely to the traditional taxonomic guidelines of adjustment disorders, dysthymia, or OCD; and (2) her racialization of my identity as Chinese colluding with my own resistance to pathologization.

…

I consistently make sense of my madness and communicate my sense-making to my GP and social worker in ways that are not conventionally observed by these helpers. I often described a tremendous amount of phenomenological detail when narrating "episodes" of my pain, and given that my file is rife with both strains in my personal life and physical symptoms, it was not easy to "locate" the categories for my imbalances. That I do not automatically wish to eclipse myself within the boundaries of terms such as OCD was an observation working against me. My GP was potentially able to dismiss this resistance as reinforcing some cultural difference in aetiologies for mental disorder. My complex storytelling was merely a testimony to my denial of my illness because I am Chinese and apparently come from a tradition of somaticizing psychic pain. That my crisis with morbid thoughts arrived during a culmination of other stressful events, such as academic failure, that were read as an obsessive occupation with my work ethic, also further racialized my experiences.

Since 1980, the *DSM-III* has now listed neurasthenia in the Appendix I under "Glossary of Culture-Bound Syndromes". It also refers users to entries for the depressive disorder "dysthymia" when found in the *DSM-II* Index. I must ask why she did not choose to diagnose me with "dysthymia", which has come to awkwardly supplant the use of "neurasthenia" in psychiatry (dysthymia does not nearly place as much emphasis on somaticization). If she is altering her rationalizing of my own sense-making through her profiling of my identity as the child of a migrant family, then what ideological process is allowing her to short-circuit my particular case to a general case of race-specific illness?

The American Psychiatric Association explains it should "be noted that all industrialized societies include distinctive subcultures and widely diverse immigrant groups who may present with culture-bound syndromes" (*DSM-III*, p. 844). Is it the case that I am the "multicultural" immigrant with an assumed culture-bound syndrome in the Toronto context? Patients do not typically request their patient records, so it seems doubtful that my GP assessed my conditions as neurasthenic with the intention of appeasing my "denial" of mental disorder and appealing to my supposed folk interpretations of the mind, body and soul. Considering the middle class

circles of academic Chinese Canadian students in the affluent North York area that would constitute part of her clinic's clientele, it is possible that she was oversimplifying the experiences of an imagined workaholic Chinese community.

Interestingly, the APA's reference to "locality-specific patterns of aberrant behaviours and troubling experiences… [that] are indigenously considered to be 'illnesses'" applies a concept of indigeneity axiomatic to a Eurocentric world view of psychiatry as objective truth (*DSM-III*, p. 844). An application of indigeneity as specific circumstance denies the historicity of Western psychopathologies themselves and assumes "folk" interpretations in "non-Western" cultures are the only geographically contingent epistemologies of madness. (Remember neurasthenia was conceived in the West, but adopted by the Chinese because it resonated with their understanding of the mind and body as one). 'Indigeneity' as exception also supposes that there are no other alternative rationales and organized ways of living beyond the mainstream medical model of psychiatry within the West, articulated by groups of people such as the psychiatric survivor community of Toronto.

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