Of Erasure and Difference: The Continuing Colonial Project in Trancultural Psychiatry

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Abstract

Drawing on the personal stories of people of colour who have been in contact with psychiatric spaces, I argue that transcultural psychiatry commits itself to a colonial project which aims to do the following: exclude people of colour from determining and making narratives about their own bodies; erase ongoing violence against people of colour; and reproduce a form of cultural racism which locates illness in the cultures of racialized others. A number of theorists, including Francoise Verges, Ranjana Khanna, and Nadia Kanani have highlighted the ways in which psychiatry was based on the colonization of bodies of colour from its very inception, and the ways in which this continues today. As a person of colour myself, who has been institutionalized within space of psychiatric "care," it is important for me to understand my story alongside the stories of other people of colour in order to give meaning to my experience that does not have to be legitimized by psychiatrists. Through sharing my own personal story and those of other people of colour, I have centered the narratives of people of colour as a major method of critique against transcultural psychiatry, and as a way to understand psychiatry through the words of those who are often left out of transcultural psychiatric discourse. The stories that I have shared give rise to themes that illustrate the ways in which transcultural psychiatry engages in the reproduction of the colonial project. These include the following: that for many people of colour, experiences with mental health systems are often intertwined with experiences of criminalization and confinement; that the history of confinement and criminalization is a cause of emotional distress and a site of further violence against bodies of colour; that transcultural psychiatry continues the tradition of cultural racism which espouses that mental illness is linked to deficiency, which is now located in the racialized cultures; and that people of colour are silenced

within both psychiatric spaces and within spaces connected to psychiatric spaces. These spaces include academic and government institutions which produce emotional distress by controlling and silencing racialized people, and neglect to fulfill their own mandate to provide mental health services for those who express a desire for them. The silencing of people of colour and the disengagement with a colonial past by transcultural psychiatrists has helped reproduce people of colour as mere objects of difference to be studied. This paper thus argues that transcultural psychiatry as a subdiscipline within psychiatry needs to address its colonial past. It more broadly understands psychiatry as a colonial construct which relies on the reproduction of cognitive difference between European and Non-European bodies – a difference without which transcultural psychiatry could not sustain itself in its current form.

Foreword

My original research question was how has transcultural psychiatry diverged or conformed to colonial narratives? It has also now come to include a general critique of psychiatry and institutions connected to psychiatric care. This paper is a product of my Plan of Study, which aims to bring different bodies of literature in conversation with each other, including literature in transcultural psychiatry; race and culture; and biomedicine. This major paper has allowed for me to understand how these literary fields speak to one another in a dynamic way, and how they critique one another. This has aided me in understanding transcultural psychiatry through a postcolonial, critical disability and feminist lens.

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Section One: Introduction

How many countless hours spent sitting across different mental healthcare professionals can be understood to reclaim a meaningful experience? Unfortunately, it is a question which I have struggled to reconcile with myself, after years of being in and out of spaces of psychiatric care without any real connection to what was going on. This paper is a product of my own interest and relationship to psychiatry, and how I have come to legitimize and understand my story through it, as a person of colour. I started by exploring the ways in which mental health professionals working within psychiatric institutions understood their relationship with people who come into contact with these institutions. This was an important step for me in order to understand my own position within the psychiatric project, and how I was seen through the eyes of mental health professionals. It was through this researching that I stumbled upon the sub-discipline of transcultural psychiatry, a field of study within psychiatry that looks at and tries to understand mental illness in different cultural contexts (Littlewood & Lipsedge, 1982). I became fascinated with the discipline for a number of reasons: one, because most of my time in psychiatric spaces was spent explaining my experiences in cultural contexts for counselors to understand; and secondly, because the discipline claims to understand mental illness through the eyes of those experiencing it (Littlewood& Lipsedge, 1982; Kirmayer, 2007; Kleinman, 1977). It is interesting for me as a person of colour who has gone through psychiatric treatment, to see the ways in which this is applied within the discipline. Further into my exploration I realized that many studies within transcultural psychiatry were situated around people of colour, including

both people of colour living outside the Western world and immigrant communities who had settled in the West (Kirmayer, 2001; Cohen et al, 2008; Jarvis, 2008; van Duijl et al, 2010; Fazel et al, 2005; Goodman et al, 2008). Transcultural psychiatry was speaking about me, a first generation child to Indian immigrant parents. I became interested in how people of colour, including myself, were positioned within transcultural psychiatry. How did transcultural psychiatry view its relationship to these people of colour who were the primary focus of their study, and how did those working within the discipline attempt to conceptualize mental illness in regards to people of colour? These questions are important for me in making sense of my own experience with psychiatrists, school counselors, mental health nurses and social workers, and reconciling my disconnect from the systems of mental health.

My reading of transcultural psychiatric literature was informed by the knowledge I had acquired in anti-racist, feminist and postcolonial literature over my years of education. These literatures provided helpful lenses for me in critically analyzing these transcultural psychiatric texts. They explore the ways in which people (especially women) of colour are depicted in academic work, through the creation of racialized discourses on bodies of colour (Levine, 2003; Spurr, 1994; Keevak, 2011; Griffiths, 2002; Deroo, 2002). Engaging with them also opened my eyes to the ways in which psychiatry was a discipline arising out of the colonial period, and tied to

racialized discourses of non-European peoples[1] from its very inception (Verges, 1999; Khanna, 2003). Psychiatry's historical links to colonialism are not only explored by feminist/anti-racist/postcolonial writers, but also acknowledged and discussed by transcultural psychiatrists themselves (Kirmayer, 2007; Jarvis, 2008; Kirmayer, 2008). Therefore, in order to answer how those working in the field of transcultural psychiatry view people of colour, I had to examine the racialized discourses that played a part in the colonization process, and consider the colonialist history of psychiatry. Thus, one of the key questions I aim to answer within this paper is: considering the colonial history of psychiatry, how has transcultural psychiatry diverged or conformed to colonial narratives?

Theory: A Look at Difference and the Gaze

It is important to highlight the theories that are guiding my research in order to understand the perspective or lens through which I am writing. The theories underpinning my work played a large part in how I chose to critically engage with transcultural psychiatric texts, and scrutinized both the written words and their implications. Postcolonial, Anti-Racist, Critical disability and Indigenous theorists have analyzed and historicized modern day discourses on numerous subjects in order to highlight historical continuity of colonial thought (Lawrence, 2003; Burman, 2010;

[1] 'Peoples' (in the plural, vs. 'people' in the singular) is used when referring to both a collective experience of racialization and the differences in how different groups of colonized peoples are racialized. Racism and colonialism oppress, regulate and construct different groups of peoples in different ways. For example, Indigenous groups still suffer from ongoing colonization of their lands, which intersects with how they experience racism and colonization, and informs their claims of sovereignty. This diversity should be acknowledged in discussing varying experiences of racism, disablement and colonization (see also Smith 2005).

Cohen, 2003; Austin, 2007; Smith, 2005)[2]. Two prominent postcolonial theorists, Edward Said (1977) and Frantz Fanon (1952), have written about the creation of difference between colonized and colonizing groups, and how this difference is maintained in a number of ways. While Said focuses on the creation of difference through literature and discourse on what he calls the "Orient," Fanon takes a more psychological approach to difference and explores the ways in which colonizers influence colonized bodies to accept and internalize an identity set out for them (Said, 1977; Fanon, 1952). Both Said and Fanon write about the reproduction of non-European people as inferior and different, through academic, cultural, political and other colonial institutions (Said, 1977; Fanon, 1952). Edward Said defines orientalism in three ways: it is an academic discipline; a style or frame of thought through which we view the Orient (loosely referring to Asia, the Middle East and surrounding areas); and a way in which institutions dealing with the Orient, such as the media and global organizations, which construct Western powers as the most economically sound (Said, 1977, p. 211, 247, 285-86). Said argues that the idea of orientalism does not need to require the Orient at all, but produces discourses and images about the Orient in order to maintain internal consistency (ibid). In this way, orientalism can reproduce itself without any contention from opposing ideologies because it has established itself

[2] Although I use these different theoretical perspective for my understanding of psychiatry and colonialism, these theoretical perspectives do not necessarily agree with each other. Both Lawrence and Smith do not use postcolonial theory in their analysis, and critique it as problematic. Postcolonial starts with the assumption that formal colonialism is over, which detracts from First Nations claims to sovereignty. Postcolonial studies also theorizes and studies First Nations groups, which is in itself a continuation of the colonial project. The goals of postcolonial theory in the academy differ from Native studies, whose primary concern is political (and defending First Nation communities) and not to contribute knowledge about Indigenous peoples in the academy. See Lawrence (2012), Smith (2005) and *Theorizing Native Studies* (Eds. Smith & Smith, 2014).

as a reference point. However, this does not mean that these discourses are floating in a vacuum; instead they are tied to institutions that reproduce discourses on people living in "the Orient" as exotic, mythological, seductive and dangerous (Said, 1977; Hall, 1980). Furthermore, the continual reproduction of Orientalist discourses cements the Orient as a monolithic and unchanging entity with a set of easily identifiable characteristics (Said, 1977). In this way, the Orient is set up as a stark contrast to the Occident (referring to the Western nations), which is thereby enabled to embody everything that the Orient is not (ibid). The Orient thus becomes a mirror through which the West asserts itself as a civilized and democratic entity, allowing Western nations to assert a superior national identity, and to carry out imperial projects on the basis of this difference (Said, 1977; Griffiths, 2002; Porter, 2004; Bush, 1999; Domosh, 2006; Bratton, 2000). Edward Said's work has been influential in how I understand the creation of difference, and the consolidated effort on the part of institutions to create the Orient and thereby also create the West as its polar opposite on the spectrum of civilization. For me it is important to understand how transcultural psychiatric work participates in these politics of difference, and how it positions itself within this nationalistic and colonial framework.

Frantz Fanon is a psychiatrist of Martinique origin, who was educated in France and practiced psychiatry in Algeria. In one of his most influential works, *Black Skin, White Masks*, Fanon (1952) highlights the eternal struggle for colonized people to define themselves against the image that the colonizer has created for them. Similar to Said, Fanon (1952) argues that colonial institutions play a large part in producing the colonizer as superior, and convincing colonized people of their own inferiority. He explains how the French asserted their language as the

language of the elite and the dominating class, and how those colonized individuals who spoke French were admired by their communities (ibid). Through the installation of French language within colonial institutes, colonized peoples were controlled and regulated to learn French if they wanted any relative success within colonial society (ibid). However, learning French did not simply mean learning the French language. It meant taking on the French identity, which was propagated as the French colonial state, and it was assumed that this French identity was easily accessible to those living in French colonized territory (Fanon, 1952). Many postcolonial theorists have highlighted the use of the rhetoric of citizenship and French nationhood in France's overseas territories as a distinctly French tool of colonialism (Cohen, 2003; Austin, 2007; Deroo, 2002). However, as Fanon and other writers point out, most colonized people living in French territories were never integrated within French society, and denied access to many jobs and rights reserved for the French people (ibid). This betrays the French promise of citizenship and brotherhood for colonized peoples (ibid). However, Fanon (1952) also argues that this betrayal is essential for the continuation of the duality of colonizer and colonized. In this way, the colonizer remains as a reference by which the colonized form their identity (Fanon, 1952; Said, 1977). Fanon's (1952) work further highlights the creation of a rhetoric of difference and inferiority for the control over colonized bodies, which colonized people come to internalize. He thus also adds an understanding of internalized racism as a source for the continuation of the colonial project through the subjugation of non-European people under the rule of Europeans. The sub-discipline of transcultural psychiatry is based on the exploration, and thus the reproduction of difference between White-Western people and people of colour, particularly the exploration of how culture affects the manifestation of mental illness. However, it is still rooted

in asserting White-Western culture as ultimately superior, and reproducing White-Western culture as the point of reference for study.

While I find Fanon helpful in understanding the production of difference by transcultural psychiatrists, it is important to note that its reception by psychiatrists contributed to the development of this sub-discipline. Francoise Verges (1999) traces how Fanon's work has been taken up by psychiatrists in order to justify psychiatry as a superior method of understanding postcolonial societies (Verges 1999, p. 208-209). After decolonization, European trained psychiatrists went into postcolonial societies in order to assist in rebuilding these societies. One method for this was the application of postcolonial psychiatry[3] to people with mental illness, based on works of psychiatrists like Fanon (Verges 1999, p. 193-194). Verges argues that Fanon partly enabled this. For example, she argues that his book *Wretched of the Earth*, which examines the psychological and psychiatric effects of colonization, failed to address psychiatry as a manifestation of colonialism, and reinstates it as a tool for liberation, and a means of control over formerly colonized peoples.

> Yet Fanon had a greater ambivalence…toward psychoanalysis and its ability to explain racism and the colonial relation. Fanon wrote 'Indeed, I believe that only a psychoanalytical interpretation of the black problem can lay bare the anomalies of affect

[3] Verges uses the term "postcolonial psychiatry" to refer to psychiatric theory in the 1960s, which attempted to incorporate postcolonial works, and create new psychiatric methodology.

> that are responsible for the structure of the complex'…Fanon often contradicted himself, stressing both the importance of psychoanalysis for understanding colonial relations and its inability to explain colonial and racial relations; he insisted that neuroses of the Negro were socially determined while giving examples of sources of neurosis that were not social (Verges, 1999, p. 209).

Verges highlights that not only did Fanon seek to understand issues facing Black peoples living under colonization through psychiatry – a regime that Verges argues furthers colonialism and racism – but he commits himself to a biomedical understanding of mental illness that evades the social causes of neurosis.

Another strand of writing that is helpful to understanding the role of psychiatry in the colonial project is antiracist disability studies. Antiracist disability theorists such as Nadia Kanani (forthcoming) and Rachel Gorman (2013) in particular have highlighted the ways in which psychiatry and other disciplines that are situated within colonial discourses. Kanani and Gorman argue that critical disability studies often reinforces the colonial project by focusing its attention on the white western universal subject, thereby privileging it as its main point of reference. People of colour, who often become disabled through ongoing colonial and institutional violence, are left out of the discussion (Kanani, forthcoming; Gorman, 2013). As Gorman explains, critical disability studies generally focuses on white western subjects who are 'disabled already', thus ignoring experiences by people of colour who are 'disabled because of' (Gorman, 2013). The assumption here is that once those who are disabled because of racism become like those who are 'disabled already,' they can be studied in a similar fashion, without regard to the

institutional violence that has led people of colour to become disabled; and to how that violence continually reproduces disablement. In regards to psychiatry, Kanani argues that psychiatry was and is a tool in the colonization of Indigenous peoples, and a site where inferiorizing images of them are produced (Kanani, forthcoming). Therefore using psychiatry as a means of understanding colonial psychiatry has to come under scrutinization by understanding psychiatry as a product of colonialism itself.

However, both Fanon and Said do provide us with an outline for understanding how the construction of difference, as established through rhetoric that is embodied within colonial institutions, has been a basis for control of non-European peoples. This understanding of difference has provided a useful basis for my analysis of transcultural psychiatric texts. More specifically, postcolonial theorists have explored the idea of biological difference as a narrative that functions within the colonial empire and paints the minds and bodies of non-European peoples as degenerative (Levine, 2003; Spurr, 1994; Keevak, 2011; Griffiths, 2002; Rogers, 2010; Abel, 1997). Bodily difference has long been a fixation of colonial discourse, and has been the basis for not only proving the legitimacy of the colonial project, but for constructing people of colour as inferior (Griffiths, 2002; Rogers, 2010). As Keevak (2011) shows, the classification of peoples into different categories based on the new science of biological descent became the norm around the early eighteenth century (Keevak, 2011, p. 43). In fact, Western texts have been the first to "propose an organization of the world according to race" (ibid, p. 45). The first instance of this being recorded was within Journal des Scavans in 1684 by the traveller Francois Bernier (ibid). It is interesting to note that many early theories of racial classification came from

accounts of those who travelled to colonized territories (ibid, p. 44). For example, Bernier describes watching naked women dance in a slave market in India and compliments the beauty of their "yellow" skin (ibid, p. 47-48). This exoticization of Orientalized women, as discussed by Edward Said (1977), was commonplace and could be found in numerous colonial travellers' accounts (Keevak, 2011). The gendering of difference, through the images of sexualized women, was one of the ways the rhetoric of difference served to differentiate bodies of colour as "effeminized" and "objectified" (Keevak 2011, p. 56). The bodily classification of peoples is also a theme in the works of Carl Linnaeus, who systematized the peoples of the world into four major groups of colour (Keevak, 2011, p. 48). In its tenth edition, the group Asiaticus fuscus, under which people in the Middle East, India and East Asia were classified, came to be called luridus (Keevak, 2011, p. 53). Luridus not only meant the colour yellow, but was also used to reference sickness, disease and death (Keevak, 2011, p. 54). This classification continued in later works, such as that of Blumenbach. Blumenbach was a German physician and anatomist in the eighteenth and nineteenth century who was one of the most influential taxonomers of his day. He based his system of classification on the shape of human skulls, and aided in the development of scientific racism (ibid, p. 59). Blumenbach was also one of the first to classify humans by race, shifting away from the common classification based on skin colour (Keevak, 2011, p. 60-61). However, the images of people of colour as dangerous, suspicious - also reflected in a longer tradition of using the colour yellow to represent deceit, as in the representation of Judas and - unhealthy, and in a state of degradation, continued to shape classifications of peoples of colour (ibid, p. 54, 62). The most interesting point here is that in most of these classifications, only people of colour were extensively described. white Europeans, on the other hand, were

either spoken about very little or not at all, thus naturalizing the white European population as the reference point for classification, and everyone else as a deviation from this "normal" form (ibid, 2011, p. 46).

This systematization of peoples into distinct categories, and specifically the obsession with classifying peoples of colour, manifested itself in many ways within the colonial empires. One of the ways in which this was done was by controlling the colonial population, which was thought to be diseased, and separating it from white Europeans in their lands (Levine, 2003; Keller, 2007; Summers, 2010). An example of this is the control of women in the colonies, who were arbitrarily assigned the label of prostitute based on their appearance (Levine, 2003). This was justified by their construction as dirty, which was also projected onto their skin colour; the idea that someone was dirty was simply based on how distant they were from whiteness (Levine, 2003, p. 195-196). The mobility of these women was restricted, and they were usually confined to certain areas within a town (Levine, 2003, p. 186-188). Many colonial travellers and administrators wrote ambivalently about women they assumed to be prostitutes: on the one hand, they were considered extremely seductive and alluring; and on the other hand, they were considered a threat to the white European race as they could be the potential carriers of mixed race children (Levine, 2003, p. 183). This line of thought is intimately linked to the idea that bodies of colour are diseased, and in turn need to be controlled, and that reproduction with bodies of colour will bring down the “white race” (Chen, 2012). The fear of becoming like the colonized population is commented on by many postcolonial theorists, including Homi K. Bhabha (1991). Hence, as stated before, the colonizer needs to assert their difference in a variety

of forms to justify the rule of the empire. The idea of bodily difference is one that occurs frequently within texts of transcultural psychiatry, as transcultural psychiatrists focus on understanding how people of colour conceptualize mental illness. However, the focus on small isolated groups of people tends to paint people of colour as primitive and irrational, holding beliefs that are not cemented in any sort of rational thinking (Kanani, forthcoming). In this way, a picture is painted of non-European populations within transcultural psychiatry as cognitively deficient, and as incapable of rationalizing mental illness in the same way as white western people, who remain the unspoken about, but readily established point of reference.

Another useful concept highlighted by postcolonial theorists is the idea of the "gaze," and the way it has influenced research on bodies of colour in order to "understand" these communities, and in turn preserve their difference (Smith, 2005; Griffiths, 2002). Communities of colour have to first be differentiated, and then that difference has to be preserved (Hall, 1980). In other words, the difference has to be preserved in order for control over these communities to persist. From a decolonial rather than postcolonial perspective, Andrea Smith (2005), argues in her book *Conquest* that cultural appropriation is common place when academics study Indigenous peoples. Often, Indigenous groups are depicted as uncivilized and cognitively unable to take on the task of preserving their own culture. Therefore, non-Native researchers feel justified in taking on this task for them.

Anthropologists were the first to take on this mission of preservation, and often looked for the most isolated groups that they could study within the colonized world (Griffiths, 2002). It is

important to note that the choice to focus on the most isolated groups is not innocent. It is in fact a reflection of asserting difference by choosing communities already assumed to be the most different. This is highlighted by how knowledge production about colonized peoples was often in the hands of those who were paid by the colonial empire to go out and fulfill the colonial project (Griffiths, 2002; Keevak, 2011; Landau, 2002, Deroo, 2002). As such, anthropologists were employed to go to the colonies and understand colonized communities in order to better control them. Anthropologists and other researchers who went to study colonized groups also played a large part in displaying bodies of colour, which served to humiliate and subjugate people of colour (ibid). As Griffiths shows, the displaying of bodies of colour served the construction of bodily difference between the colonizers and the colonized as discussed earlier. The act of staging these bodies for the European public was not only to assert these bodies as different enough to be displayed, but also as open to consumption (ibid). This consumption was most pronounced in world fairs and traveling shows throughout the European empire, and in consumer products such as postcards, cigarette packages and dishes (Griffiths, 2002; Deroo 2002; Ciarlo 2010). The staging of bodies of colour is directly related not only to the reproduction of difference, but to an ongoing history of white people gazing at bodies of colour, and disseminating images about them for consumption (ibid). This is relevant for our investigation of transcultural psychiatry, which as I shall demonstrate engages in circulating ethnographic films and other images of racialized people within the context of the academic industry. Therefore, transcultural psychiatry reproduces the gaze upon people of colour as objects of study, and exhibits them as primitive and inferior to the academic world.

Lastly, it is also important to discuss the intimate link between bodies of colour and "madness." I mentioned how difference became a means to distinguish between the colonizer and the colonized, in response to the fear, as Homi K. Bhabha (1991) has stated, that the colonizer become like the colonized. Other postcolonial theorists have confirmed Bhabha's argument, and examined numerous texts written by travellers who spoke of being driven mad by the colonial land (Spurr, 1994; Garner, 2007). Often this was cited as a surreal experience, where the traveller viewed the land as an embodiment of women of colour, who were both seductive and destructive to those who engaged with them (Levine, 2003; Dua, 2007). We find this trope in the works of many colonial authors such as Hemingway, Conrad, and Bourdieu (Keevak, 2011; Spurr, 1994). An image I would like to invoke in order to illustrate this concept is from the film *Black Narcissus* (1947), based on the colonial novel of the same name by Rumer Godden (1939). The film depicts the lives of white Anglican nuns who live in a school in the Himalayas at the very top of a mountain. They have come on a civilizing mission to educate the "Indian" population. However, they slowly find themselves being driven "insane" by their sheer presence in unknown territory. In one scene, Sister Clodagh is ringing the church bell on the highest mountain, accompanied by Sister Ruth. Both of them seem to stare beyond the horizon into the vast unknown with blank expressions. They both express their concern to each other; that they feel trapped and lost in this foreign land. The irony is that these two white Anglican nuns are standing atop the highest mountain ringing the church bell, a symbol of colonization. In the final scenes Sister Ruth is shown to be having a mental breakdown as she is overcome with lust and unable to control her feelings for Mr. Dean, a British agent who frequently visits their school. As Sister Ruth is shown to be experiencing a state of mental disruption, the camera shot constantly cuts to

images of the walls of Hindu goddesses and queens, until finally Sister Ruth throws off her white robe and dons a black dress and smeared red lipstick. This visual of Sister Ruth's journey from a white Anglican and "pious" woman to an uncontrolled force of sexual lust and desire, and arguably her transition into the "Other", has helped me understand this idea of colonial fear coupled with colonial control. The colonial fear of the "Other" fueled the project of difference, which in turned made way for projects of confinement and close control of the mobility of colonial populations. It also connects to the idea of biological racism. As discussed above, biological racism states that there is something inherent in peoples living off of non-European lands, or having connection to those lands, which makes them both cognitively and physically deficient (Summers, 2010; Keevak, 2011; Rogers, 2010; Hall, 1980). This inherent quality "forces" the colonizer to differentiate themselves from the colonized (Fanon, 1952; Bhabha, 1981). As stated earlier, theories asserting that people of different races were of a different biological makeup justified the colonial project and the superiority of the white European race. When applied to non-European peoples, "madness" is a condition reflective of their inability to fit into colonial civilized society, which in turn gives rise to their "cognitive degradation" (Jackson, 2003; Summers, 2010). However, when colonizer subjects are inflicted with "madness", it is often because they expose themselves to the colonized and their land, which are interchangeable, and subsequently experience cognitive degradation (Spurr, 1994). While biological racism has now shifted to cultural racism, physical difference continues to be mobilized as a marker of racism. I will further discuss this below, with the help of theories put forth by writers within the field of critical disability studies, in the section on Historical Continuity and Psychiatry.

Modes of Analysis

In this section, I will discuss the methods I used in order to analyze transcultural psychiatry and the use of difference in psychiatric treatments of people of colour. As stated above, I was already informed by a few bodies of literature before I started to research transcultural psychiatry. In order to expose myself to a body of literature within transcultural psychiatry, I applied to a summer program at McGill University, one of the two universities in North America, along with Harvard University, that has a subdivision of transcultural psychiatry within their medical school. I enrolled in the summer of 2013 program in cultural psychiatry, which is a crash course in the introduction to the field of transcultural psychiatry and included mini conferences. The course provided an overview of the main themes that transcultural psychiatry is attempting to address in its contemporary research, including immigration, Indigenous mental health, dissociative disorders, psychosis and others. It involved a large amount of reading and I have critically reviewed several of the key sources set in this course in my analysis of transcultural psychiatry below. After the course was over, I started to apply my readings in postcolonial theory on the history of psychiatry to what I had read during the transcultural psychiatry course. Together, this formed my analysis of transcultural psychiatry.

I then decided that instead of just reading critical literature on mental health through a postcolonial lens, I should also find literature that addresses the gaps within transcultural

psychiatric texts themselves. I discovered that lived experiences are missing from most of the literature within transcultural psychiatry. This seemed contradictory since transcultural psychiatry is based on understanding "illness" in cultural contexts, and claims to try to understand how people of colour view concepts of mental illness. It further contradicts the apparent privileging of people of colour with supposed "mental illness" in transcultural psychiatric research. Therefore, I decided to ground my research in the personal stories of people of colour who had come into contact with mental health services. I also decided to contribute my own story within this analysis, since my interest in transcultural psychiatry was primarily fueled by understanding my own lack of success with counselling. My own story of understanding my experience as a woman of colour with psychiatric labels is just one of the several stories that critique transcultural psychiatry and the wider discipline of psychiatry itself. I was inspired by Janet Mock's (2011) autobiography, *Redefining Realness,* in which she understands her experiences as a Black, transwoman of colour living in America and attempting to understand freedom not only through her own eyes, but through the eyes of women of colour who have conceptualized these concepts before her. Autobiography has been highlighted by theorists as a way to be self-reflexive of your own experience, and reclaim experiences which have been institutionalized. Borrowing from Anthony Giddens, I wrote an autobiography to dismantle the idea that mental health therapy is only received. In fact, autobiography can be self-therapy, in which one can confront themselves during past events and rewrite these events without the psychiatric gaze (Giddens, 1991, p. 72-73). It is also a way for me to honour my memory, which is "the inner place of responsibility towards ourselves and others," but often dismissed as non-scientific evidence (Demetrio, 2007, p. 254). However, autobiography goes beyond the

understanding of self, and can be written as a collective autobiography, in which past events of individuals come to highlight certain struggles (Plummer, 2001). Not only is this a reflection of my own experiences, but by placing it with other stories of people of colour, it forms a collective critique of psychiatry from otherwise silenced voices.

While collecting the literature, I found that my university library either did not stock or provided very limited access to relevant texts, including psychiatric journals, texts that were produced in universities outside of the West, and autobiographical works by artists of colour. This was a big challenge for me, but also enlightening because I realized that literature on personal experiences of people with mental illness, particularly people of colour with mental illness, is limited in the academic world. It was not found in the academic journals sitting in library catalogues. Instead, it was found on blog sites, in activist magazines, and in other personal publishing attempts by people of colour, both academics and non-academics, to reclaim histories that had been rendered invisible. Michel Foucault refers to these as subjugated knowledges, which is a set of knowledges that are both masked by the institution and considered to be on the lower rungs of the hierarchy of knowledge (Foucault, 1980, p. 82.) These subjugated knowledges serve no purpose to the functioning of a dominant institution, and are also viewed as inferior (ibid). It was these subjugated knowledge, found in the form of personal stories that I found critique against mental health systems and their treatment of "patients". This enabled me to use these personal stories as the reference point through which to understand and critique literature within the field of transcultural psychiatry.

I then decided to put the critiques provided by the personal stories in conversation with the critiques provided by postcolonial theorists of psychiatry. However, even in this aspect I found literature to be limited, as I was not able to access many sources written outside of western universities by non-European academics. However, I still managed to bring the two together, and using the critiques provided to me by personal stories of people of colour and academics of colour, I have attempted to de-center transcultural psychiatry, and in turn white psychiatrists as primary producers of mental health knowledge in the West. As a result, I was able to interpret transcultural psychiatric literature through the lens of postcolonial, anti-racist and feminist critics, and most importantly, through the critiques provided in the stories of people of colour. In doing so, I further followed suggestions by antiracist disability scholars such as Rachel Gorman (2013) and Nadia Kanani (forthcoming) to place people of colour at the center of the discussion about mental health and culture (Gorman, 2013). The personal stories of people of colour thus became the primary methodological tool that I used in order to understand transcultural psychiatry and its colonial underpinnings. I have chosen to italicize the stories of people of colour, as well as my own, in order to highlight these stories as subjugated knowledges which speak back to the discipline of transcultural psychiatry, and disrupt its claims to simply add cultural understanding to the discipline of psychiatry without acknowledging its colonial roots. Moreover, I used italics in order to remind the reader that these are distinct stories that are not my own, and that I am able to use these stories because of my privileges as an academic. What they are saying, however, is not limited to the contents of this paper, and I encourage readers to seek out these stories themselves.

I should note that my decision to focus on works of academics of colour, and academics who engaged with issues plaguing people of color, was a response to the fact that the literature within transcultural psychiatry is written by white psychiatrists, and that psychiatry is still very much a white profession (Kanani, 2011). I decided against privileging white voices over those by people of color as I aimed to de-centre white men as the primary producers of knowledge in the psychiatric field, rather than reproduce white psychiatrists at the center of the discussion (Gorman, 2013). In contrast, the counter-knowledges that have been produced by bloggers, activists, and academics of colour throw into question the ways in which psychiatry has favoured the narratives and racialized images of people of colour produced by white western psychiatrists. Their contestations highlight that psychiatry commits itself to the colonial project which asserts that knowledge produced by people of colour is meaningless, while knowledge produced by white psychiatrists warrants discussion. In contrast, through the personal stories of people of colour, I aim to show that transcultural psychiatry itself is also in the business of producing "truth", and that the knowledge it produces is not self evident. Transcultural psychiatry thus benefits off the subjugation of the voices of people of colour who contest the discipline.

Furthermore, I want to clarify the usage and function of certain terms within my paper. The way in which I use these terms is rooted in postcolonial studies and my previous studies in sociology. Firstly, my use of the word institution is affected by my sociological understanding of what an institution is and how it functions. Edgar Z. Friedenberg's (1976) article "The Conscripted Clientele" describes societal institutions as service based institutions, which construct those using them as clients. In this way, individuals become clients and consume what the institution is

selling, whether it is an idea or a service such as educating their children. However, people are not necessarily willing clients of these institutions, and often have to take part in them as a means of survival. In the colonial context, colonized people were forced to take part in colonial institutions in order to make a living (Friedenberg, 1976; Fanon, 1952). Friedenberg further highlights that institutions are interconnected to each other, and dependent on each other for their existence. He labels this a system of reference, since clients of societal institutions are frequently referenced from one institution to another. As antiracist disability scholars such as Nadia Kanani (forthcoming) and Ware, Rusza and Diaz (forthcoming) highlight, this is well illustrated by mental health institutions and the criminal justice system, as many people of colour come into contact with mental health systems as a result of their prior profiling through the criminal justice system. Therefore, the criminal justice system, which references individuals to mental health systems, can be considered a system of mental health, and vice versa. I add to this an analysis of the university which, in several of the personal stories analyzed below, emerges as an institution that creates stress through exclusion or through putting people of colour under the spotlight. Academic institutions, through connecting students to counselors and psychiatrists, also function as a system of mental health. Therefore, when I refer to any set of systems in my paper, I interrogate its interconnectedness with the plethora of institutions that aid in the maintenance of other systems.

Following the postcolonial writers whose work I have discussed, I define race and culture as social constructs. As Fanon (1952), Said (1977), and other postcolonial writers (Hall, 1980; Bhabha, 1981) have pointed out, and these constructs are repeated by those who have the ability

to produce narratives surrounding race and culture. For example, within many empires, colonial institutions of science and research produced a vast amount of literature on the functioning of colonial bodies for a colonial society which was receptive to it. This is repeated in contemporary academic practices of publishing and teaching that privilege writings grounded in racialized conceptions of culture (Said, 1977; Fanon, 1952). This again illustrates how race and culture are institutionalized, and how institutions can be powerful producers of these discourses. Postcolonial studies of race and culture have further provided us with a concept of racialization that helps us interrogate culture-bounding and other notions employed by transcultural psychiatrists, which will be explored in detail later on. In other words, discourses and images that are produced about people of colour concerning race and culture come to define and tie them to the conceptions produced about them (Hall, 1980). This is illustrated by the vast amount of literature produced during the colonial period that portrays non-European people as inferior, as discussed in my sub-section on postcolonial literature (Summers, 2010; Keevak, 2011; Rogers, 2010).

Lastly, it is important to discuss the idea of medicine and how I engage with it in my work. The field of medicine that is the most relevant to this discussion is that of biomedicine. Biomedicine is both a thought process and a methodology for carrying out the treatment of those thought to have a bodily disorder (Starr, 1982; Lock, 1996). It is a train of thought which closely aligns western medicine with the scientific disciplines of biology and chemistry (Starr, 1982). Over the years the sciences have established a monopoly over the ways in which the body can be understood, by classifying itself as objective, and based on rationality and scientific empiricism

(Starr, 1982). Practitioners of medicine in the West eagerly aligned themselves with scientific disciplines at the turn of the 19th century, in order to legitimize their practice of medicine as one that was based on objectivity and rationality (Starr, 1982). Eventually these early practitioners of biomedicine created medical institutions such as hospitals, which were claimed to keep science as the primary focus for the treatment of disease (Starr, 1982). It was through this rhetoric of science and medicine that the colonial empires justified their rule over colonized people. This was reinforced by the conception that colonized people' understandings of the body were based on cultural understandings of disease, rather than objective understandings of science (Kanani, forthcoming). This paper thus also explores what part biomedicine's close investment in science has played in the subjugation of colonized bodies.

Chapter Guide

In the first chapter of this paper, 'Historical Continuity and Contemporary Theory', I will discuss in greater depths how bodies of colour have been constructed through colonial narratives, and how these constructions have continued in the field of transcultural psychiatry. The theories presented within this chapter, combined with the postcolonial literature already highlighted in this chapter, inform three major critiques that I have of transcultural psychiatry. These critiques are as follows: that transcultural psychiatry continues to silence the voices of people of colour, which aids in the propagation of the colonial framework of difference discussed above; that transcultural psychiatry still views bodies of colour as inherently responsible for their own distress, even if it is deeply invested in the shift from biological racism to cultural difference; and that transcultural psychiatry has built itself on the project of cultural difference, but does not

discuss the everyday institutional violence directed against people of colour, which breeds mental illness within communities of colour.

In the second chapter *Historical Continuity and Psychiatry* I put the critiques stated above in conversation with themes that arose out of the stories of people of colour. I cite these stories in order to critically scrutinize texts within transcultural psychiatry. Through this, I come to the conclusion that transcultural psychiatry is a contemporary manifestation of colonial medicine. Even though it offers itself up as a new method of analysis within psychiatry, it still bases itself in a colonial narrative.

Section Two: Historical Continuity and Psychiatry

In this chapter, I engage with contemporary theorists who have discussed the historical continuities of colonialism in psychiatry and mental health. Continuing from my earlier discussion, the colonial project was rooted in the universal norm of the quintessential white, European and healthy body, whose constitutive outside were the colonized bodies of colour, who were seen to be diseased and in an unchanging state of degradation (Keevak, 2011; Griffiths, 2002; Rogers, 2010; Spurr, 1994). The "madness" or "insanity" of colonized people was often stressed by colonizers in order to highlight and assert the superiority of the cognitive abilities of white European bodies, but also to further control people of colour (Keevak, 2011; Griffiths, 2002; Rogers, 2010; Spurr, 1994; Summers, 2010; Verges, 1999). One of these mechanisms of control was through the use of psychiatry, and the language of science and biomedicine which came to aid psychiatry, touting itself as the most "rational" and "objective" way of understanding the human body (Verges, 1999). Critical theorists have applied insights from postcolonial theory in order to draw attention to the continuation of colonial thought, which saw colonial bodies as diseased and in need of control. Psychiatry, as a control mechanism, came to embody this colonial narrative in a particular way.

Ranjana Khanna (2011), a critical theorist, outlines the colonial roots of psychiatry in her book *Dark Continents*, and traces how the development of modern psychiatry with Sigmund Freud has come to embody these colonial narratives. Khanna (2011) brings together different historical

periods to show the ongoing thread of colonialism that remains ever present. She ultimately claims that psychiatry was never without colonial rhetoric, and should be viewed as such. Psychiatry, according to Khanna, has always promoted a "masculinist and colonialist discipline that promoted an idea of Western subjectivity in opposition to a colonized, feminine, and primitive other" (Khanna, 2011, p. preface). Feminizing the body of racialized others is a practice employed by colonial institutions in order to emphasize that power in the hands of the white European male is the ideal. This is repeated in the association of women of colour with unchecked sexual desires, which is closely linked to insanity in the colonial context (Keevak, 2011; Levine, 2003; Dua, 2007). Interestingly enough, unchecked sexual desire is also a concept employed by Freud in order to explain the development of mental illness (Khanna, 2011). Khanna (2011) writes extensively about Freud, often referred to as the father of modern psychiatry, and his concept of psychoanalysis, to showcase how modern psychiatry was loaded with colonial narrative and imagery from its inception.

Khanna states that the emergence of psychoanalysis as a discipline, or the emergence of psychoanalysis theorization, began "simultaneously with the theorization of nationalism and at the height of colonial expansion" (Khanna, 2011, p. 5). Sigmund Freud himself admired archaeologists such as Heinrich Schliemann, Henry Morton and others. According to Khanna, Freud praised Schliemann's work, Schliemanniad, as it expressed his own desire to "travel to a place of antiquity" (Khanna, 2011, p. 39) Khanna further argues that Freud had an immense love for archaeological treasure, particularly that from the period of antiquity (ibid, p. 42). This appreciation of antiquity through archaeological revival was very much a nationalistic project,

meant to express the great power and intelligence of the European race (ibid, p. 45). Alongside these archaeological uncoverings was the rise of Darwin's theory of evolution in the mid-nineteenth century, which legitimated archaeological study as a means to show the advancement or the previous stages of evolution of European societies (Khanna, 2003, p. 45). The nationalistic project apparent in archaeology and anthropology, and the employment of evolutionary tactics, such as at the world fairs, which found their basis on the differentiation and hierarchical arrangement of peoples, is the backdrop for the formulation of Freud's theory of psychoanalysis (Maxwell, 1999; Griffiths, 2002).

It is against this backdrop that psychoanalytic theory was formed, and that we can understand Khanna's concept of "worlding." Khanna defines the concept of "worlding" as closely linked to "the way of being" (p. 4). The way of being relates to how any one person or subject of study is brought in, and situated within existing social frameworks. She uses the example of art to further illustrate her idea of "worlding." She argues there are two levels of art. In the first, the production aspect takes place and something is brought into being (Khanna, 2003, p. 4-5). The second level refers to the ontological purpose that the art piece serves, and how that piece of art reproduces discourses circulating within existing social structures (ibid). In other words, art is not just a representation of something that already exists, but has the ability to reproduce existing discourses in a new way. Khanna (2003) argues that psychiatry engages in what she labels as the process of "worlding" or more simply, the idea that something is being produced and given social meaning simultaneously (ibid). She (ibid) further elaborates that this is a violent social process, which is inherently full of "strife" (p. 5-6). This is because within the colonial context

the process of worlding renders colonized bodies as the "earth" and colonial authorities as those who "unearth" the bodies of colonized peoples, by bringing them into existing discourse and giving them meaning in existing colonial structures (ibid, p. 10-13). So when Freud labels the minds of women as the "dark continent" he relies on the images of exoticized women of colour that were already in circulation, but also aligns the concept of dark continent to new psychiatric understandings of people of colour (ibid, p. 49). The "dark continent" as a vast unknown which colonizers explored, and brought the "light of civilization" to, was already a concept that had been structured by colonial institutions (ibid, p. 100). However, Freud expanded the idea of the dark continent to speak of the minds of colonized people, which would be unearthed by psychoanalysis. Psychoanalysis thus brought to light an understanding of the minds of colonized people (ibid, p. 100-101). One way to unearth these was through the mode of speech, in which the colonial psychiatrists asks specific questions of people of colour. Freud's theory is indicative of the power dynamic that was set up during colonialism, in which the colonized peoples needed the colonizer in order to exist (Fanon, 1952). In this way, only when the colonizer acknowledged colonized subjects in ways that racialized or subjugated them, were they brought into existence into the colonial social framework (Said, 1977; Fanon, 1952). Khanna's (2003) concept of worlding resonates with concepts by Fanon, Said and other writers discussed earlier, that place emphasis on the disproportionate amount of literature which is produced by the colonial empire on colonized peoples without any basis in real evidence. Psychiatry thus brings forth concepts about racialized people that are cemented in the process of studying and producing images about them, and that justify their control. Worlding thus refers to the ways in which colonized people are studied by psychiatrists, where concepts of mental illness are created for the purpose of

controlling colonized people, and extending the colonial gaze. This constructs racialized people as the concealed, or those who need to be spoken for. They are consistently silenced within transcultural psychiatric literature, because in order to be controlled they need to be constructed as passive objects for the production of racialized images (Fanon, 1952; Spivak, 1985). This silencing of the voices of people of colour, upon which the discipline of transcultural psychiatry relies, is the first critique that I have of transcultural psychiatry.

Critical disability theorists have expanded this concept of silence to include not only the silence of people of colour within mental health literature, but the silence of psychiatrists about white populations when it comes to the discussion of culture and mental health. There is an obsession with isolated communities as sites of study, a practice that was formed under the colonial regime, and is reflective of the colonial narrative of difference and the establishment of difference in scholarship. As discussed before, Nadia Kanani (forthcoming), a critical disability theorist whose work highlights the lack of scholarship on race and disability, argues that the default figure of study that is prominent in critical disability literature is a white, culture-less, race-less individual with a disability, because the concept of culture is always already over-determined as that of racialized people. Not only does this establish the white body as a reference point for studies of mental health; but also establishes biomedicine as the reference point for treatments of mental health (Kanani year; Meekosha, 2011). Sarah Nelson (2012) argues that mental health services in Canada are still within the fold of the colonial project, and disadvantage any groups which have alternative forms of attending to the mind and changes occurring within it. The absence of Western science within certain racialized communities and their use of alternative forms of

treatment is regarded as inferior (Kanani, forthcoming). These alternative forms of treatment are seen as "cultural" medicine, and as medical anthropologists have argued, biomedicine is seen to be without "culture" (Hughes, 1992; Good, 1994). Instead, the study of alternative forms of medicine is seen as cultural knowledge, and biomedicine is viewed as the study of real knowledge based on scientific fact (Nelson, 2012). Therefore the white European body constitutes a norm that we all know and are expected to aspire to, while the racialized body is something we must discover, thus rendering the exploration of the racialized body as the true study of culture. As long as White Europeans' bodies remain unmarked within psychiatric literature, they are continually centered.

Nadia Kanani, in her article "Critical Conversations; Examining the Relationship Between Disability, Racialization, and Settler Colonial Governance", highlights the ways in which the absence of a critical analysis of western biomedicine from the study of cultural medicine and psychiatry undergirds the idea of the "primitivity" of bodies of colour.

> While metaphors of primitivity are not new to psychiatry, in characterizing indigenous communities and lifestyles as primitive, psychiatry has legitimized constructions of indigenous people as inferior relative to the white settler. Importantly, these stereotypes have been frequently invoked to justify colonization. Thus, as Waldram (2004) states, 'i[n] many ways, the story of psychiatry's gaze upon Aboriginal people is at least in part also the story of the relationship between the development of psychiatry itself and broader processes of European colonization' (p. 8).

Kanani argues that the representation of Indigenous communities as primitive justifies the psychiatric intervention by non-Indigenous people into Indigenous bodies. Like Nelson, Kanani shows that this is justified by the alignment of European culture with science and objectivity. Indigenous communities are said to lack science and objectivity, which is reflected in psychiatric scholarship through an emphasis on their "primitivity" and lack of "civilization" (Kanani, forthcoming). Therefore psychiatry, backed up with scientific "evidence", needs to address these communities. This serves to naturalize scientific positivism as a means to address cultural deficiency in communities of colour, which are thought to be a breeding ground for mental illness (Kanani, forthcoming; Smith, 2005).

There is a shift from a psychiatric perspective that views bodies as inherently diseased, to a psychiatric perspective that views certain cultural contexts to be deficient, and as grounds for producing mental illness and deviance. Francoise Verges (1999), the postcolonial theorist already discussed in the introduction, makes the argument that at the turn of the twentieth century, there was a shift from biological to cultural racism in "colonial psychiatry", which is a label she gives to the period preceding modern psychiatry (p. 194). Colonial psychiatry came out of ethnographic studies which attempted to understand the Native population through observation, a tool used in many early anthropological studies, as previously discussed (Verges, 1999, p. 201). It promoted itself as a project of assimilation, where assimilation meant restructuring society in order to better understand and control the Native population (Verges, 1999, p. 194). Verges (1999) states that instead of "subjugation by force", psychiatry posited itself as a project of "progressive assimilation," or as a sort of soft colonialism (p. 201). It was

during the 1960s, with the rise of anti-colonial thought, that psychiatry started adopting new discourses (Verges, 1999, p. 193). Verges (1999) argues that during this period western educated psychiatrists went back to the former colonial states to offer their services as psychiatrists to Native populations (p. 193-194). Within this modern psychiatric framework, psychiatry was seen as a tool that could reform postcolonial societies. Indeed, many colonized populations encouraged the use of psychiatry for understanding their own situations (Verges, 1999, p. 194).

The psychiatrists who made their way back to former colonies in the sixties were also educated within the anti-colonial framework; as already mentioned they were familiar with postcolonial theorists such as Fanon (ibid, p. 192). Psychiatry came to be viewed by both psychiatrists and colonized people as a tool for the betterment of society. Many psychiatrists utilized an anti-racist agenda that attributed mental health problems to the colonial history within which they were arising, rather than the biological deficiencies of colonized populations (ibid, p. 194). Verges (1999) argues that psychiatrists began to occupy themselves with native populations who were suffering from mental illness. However, it was the acknowledgement of the history of colonialism itself that "perpetuated its denial" (Verges, 1999, p. 194). Psychiatric literature coming out of the 1960s posited that native populations were unable to move out of their past and enter modernity, and thus began to exhibit high rates of mental illness (Verges, 1999, p. 194).

The psychiatrists who made their way back to former colonies in the sixties were also educated within the anti-colonial framework; they were even familiar with postcolonial theorists such as

Fanon (Verges, 1999, p. 192). Psychiatry came to be viewed by psychiatrists and people of the colonies as a tool for the betterment of society, which utilized an anti-racist agenda that analyzed the colonial history in which mental health problems were arising, and not the biological deficiencies of colonized populations (Verges, 1999, p. 194). Verges (1999) argues that psychiatrists began to occupy themselves with native populations who were suffering from mental illness. However, it was the acknowledgement of the history of colonialism itself that "perpetuated its denial" (Verges, 1999, p. 194). Psychiatric literature coming out of the 1960s posited that native populations were unable to move out of their past and enter modernity, and thus there were high rates of mental illness within the former colonies (Verges, 1999, p. 194).

This "postcolonial" psychiatry, which used postcolonial theory extensively, was posited on the idea that western psychiatrists were needed in order to save formerly colonized people from the effects of colonialism. It is here that we find the basis of transcultural psychiatry (Verges, 1999). This idea again resonates with the concept of the psychiatrist who uncovers the psychiatric subjects of study as the "earth" (Khanna, 2003). The uncovering process supports a paternalistic relationship between the psychiatrists and the "patients" of psychiatric care, which is reflective of the overall relationship between colonizer and colonized as one that asserts the cultural superiority of one group over another. The establishment of cultural psychiatry as a new and superior method for treatment of mental illness aligned itself with the discipline of anthropology, which at the time had yet to establish itself as a legitimate discipline in the study of culture (Verges, 1999, p. 203). However, Verges (1999) argues that this new psychiatry was still an offshoot of colonial psychiatry. It had just wrapped itself in the language of inclusion, and

positioned itself as a radical alternative to colonial psychiatry, while still reproducing the colonial gaze upon colonized bodies (Verges, 1999, p. 204-205). Through Kanani and Verges we see that there is a shift from biological racism, under which colonial bodies were thought to be diseased, to cultural racism, which attempts to treat the cultural etiologies of mental illness. Highlighting the complicities of transcultural psychiatry with cultural racism thus constitutes my second critique of transcultural psychiatry.

Cultural racism puts emphasis on the culture of racialized people as a cause for psychological disturbance, but also goes further in ignoring the institutional violence experienced by racialized people and the ways in which it contributes to psychological distress (Meekosha, 2011; Gorman, 2013). Antiracist disability theorists have laid out the ways in which psychological issues affecting people of colour have often been ignored in their institutional contexts, thus invisibilizing the everyday violence that people of colour face from white European institutions. Nadia Kanani (forthcoming) and other critical disability theorists have highlighted the ways in which critical disability studies lack a meaningful understanding of race and mental illness, as race is seen as a lens of analysis that can simply be added onto the study of disability (Meekosha, 2011; Gorman, 2013). Kanani argues that mainstream disability studies have often focused on the "heteronormative, gender normative, white western subject," which we have argued produces the white western subject as the reference point for our understanding of disability (p. 1). She also adds that disability studies have focused on disability as an "identity based category" and a simple "rights based issue" (p. 2). However, this once again treats disability as an individual rights issue without addressing the production of disability within the colonial context. Even

though critical disability studies employs a social constructionist perspective, it narrows its discussion to the simple exclusion or inclusion of individuals with disability into institutions that have excluded them (ibid, p. 2-3). However, similar to other postcolonial theorists previously mentioned, Kanani argues that the psychiatric institution has always been a means to control and regulate people of colour, and that this narrative has continued until today. It thus does more than simply serve the institutional inclusion of people of colour. Rather, these very institutions are built on promoting the difference between white European bodies and bodies of colour, and sustaining this difference as a means of control (ibid; Verges, 1999). However, here we see a shift within transcultural psychiatric literature. It is not so much the promotion of difference explicitly, but the erasure of difference within academic literature which reproduces the colonial workings of these institutions (Kanani, forthcoming; Smith, 2005). Texts coming out of the colonial period committed themselves to studying both the body and cultural differences of non-European groups. However, although transcultural psychiatry continues to explore difference through studying and classifying cultures of non-European people, it erases differences between white western and racialized groups by eradicating the institutional violence experienced by racialized people, therefore favouring and limiting themselves to a concept of culture that observes and makes inferences about groups of people based on rites of passages and ceremonies.

A way in which to understand this is through the work of Rachel Gorman (2013), introduced earlier, who puts forth two distinct categories in order to understand the reproduction of colonial narrative through the erasure of difference; those who are ‘disabled already’ and those who are

"disabled because of" (Gorman 2013, p. 2). There is, then, an assumption that there are "deserving" disabled people, who have come to disability through no fault of their own, as opposed to those who are "disabled because of", through their own fault (Gorman, 2013). However, we can expand Gorman's definition of "disabled because of" to include those who are thought to be disabled because of their culture. This spin on Gorman responds to how in many of the personal stories discussed in the following chapter, people of colour expressed assumptions of mental health institutions which treat communities as disabled because of their cultural deficiencies. Within transcultural psychiatry, there is a concept of "culture-bound" syndrome, which focuses on the ways in which mental illness manifests itself in non-European cultures. It is labeled culture bound because it is thought to be a unique manifestation pertinent to a certain place and culture. However culture-bound syndromes are always discussed in reference to the study of non-European people. This way, the culture of non-European people becomes a site where irrational manifestations of mental illness become produced. Furthermore, this concept limits discussion of culture to specific phenomena in specific places, but does not address any overarching experience of racialization and institutional violence that people of colour face, which also very much a part of their lived reality (Kanani, 2011; Verges, 1999.) Therefore, the erasure of everyday violence carried out by societal institutions, which causes mental distress within people of colour, is my third critique of transcultural psychiatry.

I have presented three critiques of transcultural psychiatry emerging from postcolonial and antiracist disability literatures in this chapter. Firstly, I have argued that transcultural psychiatry is a discipline that is dependent upon the silencing of people of colour. Secondly, I have drawn

attention to its reformulation of colonial narratives under the guise of culture. Thirdly, I have argued that it erases the role of different institutions in creating emotional distress in the lives of people of colour. In the following chapter, I will argue that the silencing of people of colour, the propagation of cultural racism, and the dismissal of institutional violence, are also themes that can be found within personal stories by people of colour.

Section Three: A Collection of Stories of People of Colour (POC) and Psychiatric Care

As a woman of colour who has been trying to work through my experience with psychiatric therapy, I find that I have often resorted to speaking of myself as a psychiatric subject of study, and to making use of labels provided to me by the psychiatric system. Unfortunately, understanding my experience this way has been painful. I have continually de-centered my own awareness of myself and my own understanding of what I am going through, in order to center and speak about my experiences through the labels of: clinically depressed, generalized anxiety disorder and manic episodes. In this chapter, I want to bring forth personal stories of people of colour, as well as my own, in order to bring visibility to voices which have often gone unaddressed within critical texts about psychiatry. Alongside this, I will also analyze and critique transcultural psychiatry through the lens of these stories in order to highlight these personal stories of people of colour as an important reference point for understanding culture and mental health. I thereby hope to place people of colour both at the center of the discussion about culture and mental health, and as the primary source of critique, and thus as able to decenter transcultural psychiatry. As mentioned earlier, the white western body is often centered as the unspoken point of comparison against which bodies of colour are measured (Keevak, 2011; Griffiths, 2002; Maxwell, 1999; Rogers, 2010; Levine, 2003; Dua, 2007). Therefore, it is crucial that I center the experience of people of colour who have been labelled or not labelled mentally ill, and what that entails: how psychiatric and mental health services treat people of colour; how people of colour have understood their experience; and how their experiences have spoken to them. Through bringing together these different voices, and highlighting them as collective experiences, I hope to validate the personal experiences of people of colour in regards to what they define as their mental health, and decenter psychiatric understandings of them.

Before discussing some of these critiques and sharing some of the personal stories of people of colour, I would like to state that the themes generated on their basis are my own contributions to a growing body of collective critique against the psychiatric regime. At the same time, it is important to highlight that the issues expressed in the stories introduced in this chapter are much more complex and nuanced and deserve to be read outside the context of this paper.[4] NICE

People of colour have had a long history of oppression under the psychiatric regime in North America, which has often been ignored. The treatment of those considered mentally ill has often been spoken of as a collective history of an oppressed population. However, these sorts of narratives invisibilize the struggle that people of colour have specifically had with the psychiatric regime (Gorman, 2013; Meekosha 2011). At various points in North American history, people of colour have been criminalized, decriminalized, institutionalized and deinstitutionalized on the basis of their race. They have often been labelled "insane", and locked away in hospitals or asylums, because they were seen as a threat to society (Jackson, n.d.; Yellow Bird, n.d.). Many found themselves in institutions because they spoke out against authority figures, or acted out of line with the perceived image of a docile person of colour (Jackson, n.d.; Yellow Bird, n.d.; Summers, 2010; Jarvis, 2008). In this way, the pathologization of people of colour has been

[4] Please see Chapter: A Collection of Stories of People of Colour (POC) and Psychiatric Care. There are a collection of stories there, which I have summarized. I understand that since they are summaries, there are many other themes within them that I was not able to explore.

closely linked to criminalization. When people of colour did something that went against white European authority figures, they were confined in asylums or thrown into jail (Jackson, n.d.; Yellow Bird, n.d.; Summers, 2010; Jarvis, 2008; Ware, Rusza, and Dias, forthcoming).

This type of institutional violence is absent from most of the transcultural psychiatric literature, which instead chooses to focus on "culture-bound" syndrome. The erasure of institutional violence is the thread which runs throughout the stories of people of colour who have come into contact with systems of mental health. These themes are the following: the confinement and criminalization of people of colour and its relation to mental illness; the dismissal of concerns of people of colour within other mental health institutions; and the silencing of people of colour within psychiatric spaces. I will then highlight how these categories aid in silencing people of colour, promoting cultural racism and dismissing the ways in which western institutions continually cause emotional distress for people of colour.

Confinement and Criminalization

The first theme I want to address is the confinement and criminalization of people of colour who engaged with mental health institutions within the personal stories I came across. We have already looked at the ways in which confinement of individuals is a product of the colonial project, and one which functions to further control the bodies of racialized people. The criminalization and confinement of people of colour is a very violent process, one which also creates disablement amongst people of colour, and renders them "disabled because of" this process, and further adds to their distress (Gorman, 2013). Through this process, there is a large

scale erasure of the institutional violence propagated by psychiatric institutions on bodies of colour, and a focus on internal cultural "deficiencies" of communities of colour as the cause of distress amongst them (See: Kirmayer, Tait, and Simpson, 2008; Kirmayer, Fletcher, and Watt, 2008; Kitayama and Park, 2007). In this way, the criminalization of people of colour suffering from mental distress serves to silence the voices of people of colour in order to reproduce images of them as irrational and out of control.

Abla Abdelhadi (2013), who identifies herself as a Palestinian "womyn", a radical disability justice advocate, and a community builder, describes how she was taken by the police after having her first manic episode outside of a bar in Minnesota, where she was accompanying her mother for chemotherapy for treatment of cancer.

> *The police were called right away. Still in shock and stunned that I could get arrested for sitting on a sidewalk and laughing, I was taken by the police to a mental health detention centre (para. 2).*

Abdelhadi (2013) was not provided sympathy or offered any sort of assistance. The first response of those around her was to call the police. However, instead of helping her, the authorities dragged her to the police station and locked her up for the night. Abdelhadi's identity as a Palestinian and as a womyn was pushed to the forefront of her experience the night she was inside the jail cell.

> *Overnight, I was tortured in ways that targeted my intersecting identities of disability, gender and race. Rather than help me get grounded from my first manic episode, I was subjected to humiliating scenarios of white men pretending to pray like Muslims in*

> *mocking racist ways. Rather than helping me find a safe space when I identified as a survivor of male violence and child abuse, I was locked up in a room with a male against my will (para. 2).*

Fearing that the police may get violent with her inside the detention center, Abdelhadi made the decision to run away from the detention center (para. 2). She was captured and forcibly hospitalized for ten days and given the labels of "sex addict" and "bipolar" (ibid). Alongside this, she was also charged for breaking the window when she ran out of the detention center, and had to pay large fees to lawyers in order for charges against her to be dropped (ibid). Abdelhadi's story encapsulates the violence through which people of colour are brought into psychiatric care. Moreover, the silencing of her pleas for help, and her later diagnosis of biopolarism and sex addiction, sustain an orientalist image of her as an irrational, sexualized body of colour (Said, 1977; Ware, Ruzsa, Dias, forthcoming). Within this racialized diagnosis we also find that Abdelhadi's mental distress is rendered a problem that is inherent to her, while the distress caused by the violence of the police is dismissed. The police was also my first point of contact when I was hospitalized for a recent suicide attempt in 2013.

> *After attempting suicide, something I did not follow through with, I frantically called my sister for help. My sister, who was afraid for my safety, dialed 911 when she could think of nothing else. I was brought to the hospital after being picked up by two police officers outside a Sikh place of worship, also known as a Gurdwara. I couldn't quite understand why I was pulled out of the Gurdwara and thrown into the back of the police car, why I was asked to keep my hands in the air for the officer to see, and why the police had to follow me around the hospital, even into intimate spaces like the washroom.*

This experience left my sister and I very shaken, and my sister regrets making this call to this day. I remember how I pleaded with the cop that I was "sorry" and attempted to share my history of sexual violence. Instead, he pushed me into the car and replied "Keep your hands where I can see them." The violence of that experience and the affirmations by mental health workers concerning the "kindness" of the cop caused me even more emotional distress and anxiety than before I had been brought in. I could not fathom the thought of having to attend to mandatory counselling within the very same system that had inflicted violence upon my body. Later on, when I began visiting my therapist for mandatory counselling sessions, I remember sitting down with her and trying to express why I had attempted suicide.

> *I tried expressing how dealing with men [given my history of sexual violence], lack of support from my professors and university administration, and general struggle transitioning into graduate school, were the reasons I wanted to commit suicide. She would brush that off and say, "But you're doing well in school?" I would reply, "Yeah, I guess." She would then discuss in length my family history, my family dynamics, and constantly remark, "I understand sometimes it is hard for people to open up because in certain cultures you're not supposed to discuss these things." I would nod mindlessly, because I didn't feel like I could steer the conversation back. She was white and didn't understand the importance of colour in my life. She took issue with the fact that I was raised by my dad's sister the first couple of years of my life, something she could not wrap her head around. She even went as far as saying, "I don't know what kind of mother would send her daughter off to another woman in her crucial developmental years." All my problems with anxiety and depression came back to my absent mother in*

my early years. What she failed to understand was that this was not just some random woman, this was my bhuaji (my dad's sister) and in my family, a large Indian family, family did not just mean your parents and siblings. She couldn't move past it; she thought I had been deprived of a mother's love in my early years, an ideal she held in high esteem. Most of our appointments were focused around what she wanted to focus on, and she always told me I was "strong" for opening up, when in fact I was not strong, but made to feel "weak" because there was a whole part of me I could not open up about and I felt forced to keep silent because it could not fit into my therapist's diagnosis.

I was forced to keep silent because what I was saying was not important to my therapist's understanding of what was causing emotional distress within my life. Instead, she needed to commit to an understanding of my emotional distress through a cultural lens. She needed to seek out the ways in which I was deprived through my culture, and how this caused me anxiety. I was "disabled because of" my Indian identity, not because of the way in which the academic system treated people of colour (Gorman, 2013). In this way, the etiology of my emotional disturbance was situated within my cultural background, which deviated from the way in which kids were meant to be raised in the Western context. I was "sick" because I was different, and my therapy sessions were a testament to that fact the same way transcultural psychiatry is.

Another case, widely circulated in the media, was that of NBA star Delonte West, who was arrested for possessing firearms within his car. However, the media chose to ignore that West had been diagnosed with bipolarism, and had been on a drug called Seroquel for quite some time. The night of the arrest he recalls that after dozing off he woke to his mother yelling at him to

kick his friends out of their home, as they were playing with his gun collection. He decided to remove his gun collection to an empty home he owned nearby. As he was driving he realizes:

> *I'm dozing in and out. I open my eyes and I went from this lane to that. I'm swervin', and by the time I wake up, I'm about three exits past my exit. There's this truck flying beside me...and I'm scared to death. So I seen an officer coming up and I try to flag him down. I pull up next to him. He slows down and I get up in front of him. I tell the officer I'm not functioning well and I'm transporting weapons… The rest of the story is what it is (Tzvi, 18-19).*

Delonte shares how he later faced scrutiny from the media, fellow team members, and fans. He was first and foremost a black man, who was in possession of guns. This adheres to the image that the media, and other institutions circulate of racialized men in general, as inherently violent and angry.

> *They put it all in one sentence...Delonte's riding a motorcycle, he's bipolar and that's why he missed that shot, period (Tzvi, 24).*

David Leonard (2012) argues that because Delonte was Black he became criminalized first, and seen as a mental health patient later. Although Delonte was attempting to seek help from the police, he became criminalized instead and put behind bars. Thus, a complex moment of what he describes as "extreme sadness," in which he was on Seroquel and feeling a range of emotions, became limited to the fact that he was Black and had a weapon on him (Leonard, 2012). Through the criminal justice system, Delonte's experience with mental illness was invisibilized in favour of an image of an angry young black man (Leonard, 2012). The initial silence of the media on Delonte's cause of emotional distress, and later the attention on his diagnosis of biopolarism,

reproduces the image of a violent young man of colour, who was unable to control himself. However, the media subtly dismisses the primary response of the police officer to arrest Delonte when he pleaded for help.

Ware, Ruzsa and Dias (2014) highlight the role of the prison industrial complex in disabling people of colour, which they define as a "set of interests created and maintained to support capitalism, patriarchy, imperialism, colonialism, racism, ableism, and white supremacy" (p. 1). Moreover, the prison industrial complex produces racialized images of people of colour, whether as women who produce men of colour who are criminals through poor motherhood, or as men of colour who continually break rules of the law (Ware, Ruzsa, and Dias, 2014, p. 1-2). Their article contributes several stories of men of colour who are currently within the confines of the prison system. One such story is the story of a young Micmac man who found himself within the prison system through violence experienced at the hands of the residential school system and later psychiatric care.

> *I am writing this story on behalf of an individual who has been in prison for over 20 years serving a life sentence. As a young Micmac he was often in trouble with the nuns that ran the [residential] school he was sent to. Eventually, because of his inability to conform to the nun's demand of "silence and subservience" they sent him to the psychiatric asylum (prison) at the age of 9. It was at this facility [that he] was raised to adulthood and when he was 21 years old the asylum released him from their custody...with a lack of social skills and [the] deep loneliness of a person raised in a psychiatric prison he soon began to use drugs. It was not long after this that in a horrible*

> *turn of events...someone was found murdered [and he was arrested].The violence within residential schools against and its affect on the mental health of First Nations groups has been very well documented, especially amongst First Nations groups themselves. Many former students of residential schools suffer from emotional trauma of the experience, yet it is something that has gone unaddressed by the prison institution, which advocates for the mental well being of prisoners but severely limits how prisoners can go about accessing mental health services (ibid, p. 6).*

The nature of prison as a site of "overcrowding; violence; solitary confinement; lack of privacy; separation from family and friends; lack of meaningful activity; and uncertain futures in terms of housing, work, and relationship" produces or reproduces mental distress amongst its prisoners (Ware, Ruzsa, and Dias, 2014, p. 14). The violence against this young Micmac man was not addressed by the prison system. Instead, it was reproduced through the dismissal of his residential school experience, which contributed to his emotional distress (Ware, Ruzsa, and Dias, 2014). The violence against First Nations people through the residential school system becomes invisibilized. The narrative that is being reproduced instead pins the problems of First Nations people on drug use and alcoholism within their communities. Whereas during the colonial period, the bodies of First Nations people had to be described as different through the rhetoric of being inherently diseased, the focus has now shifted to produce the image of cultural depravation through alcohol and substance abuse that has been self inflicted by First Nation groups on themselves.

In fact, the literature provided to me on the mental health of Indigenous people in the transcultural psychiatry course at McGill University similarly limited its understanding of Indigenous mental health. It stressed the difference of Indigenous concepts of mental health, which were usually painted as "holistic" and deeply connected to the land and surroundings around them (Kirmayer, Fletcher, and Watt, 2008). Drawing on Nadia Kanani's (forthcoming) earlier statement, the study of Indigenous people by psychiatrists usually limits itself to studying the cultural variation of mental illness in Indigenous people. It thereby also serves to reproduce the very difference on which the sub-discipline of transcultural psychiatry rests. This difference needs to be studied for the very reason it is so different from Western conceptions of mental health. However, through studying the different between mental health concepts of Indigenous people, transcultural psychiatry paints a picture of Indigenous concepts of mental health as "primitive" (Kanani, forthcoming). Without scrutinizing white Western bodies and Western conceptions of mental health, it subtly asserts the superiority of Western conceptions of mental health as those that need not be understood because they are self-evident and universal. This not only applies to transcultural psychiatric literature that deals with Indigenous groups in North America, but also applies to the general study of isolated Indigenous groups in non-Western contexts. Through this we see the practice of cultural racism manifesting itself, as Indigenous people are presented as "strange" and worthy of study, while white Western bodies are normalized as "civilized" and "rational."

Transcultural psychiatric literature chooses to acknowledge that many Indigenous groups faced colonization in the past without, however, acknowledging that colonization also occurred, and

continues to occur outside of the Americas (Kirmayer, Fletcher, and Watt, 2008; Kirmayer et al, 2011; Kirmayer, 2007). Indigenous people in North America, and around the world, are still facing ongoing land seizures, severe poverty, and lack of access to institutional services through which they can address issues of mental health (Smith, 2005; Lawrence, 2013). As Smith and Kanani have argued, First Nations groups also continue to be the objects of studies which showcase extreme examples of difference between non-Europeans and white European peoples (Smith, 2005). However, transcultural psychiatry fails to historicize colonization, and only pays homage to colonial history as a means of understanding current disruption within these communities (Kirmayer, Fletcher, and Watt, 2008; Kirmayer, Tait, and Simpson, 2008; Kirmayer et al, 2011; van Duijl et al, 2010; Kirmayer, 2007). As Verges (1999) pointed out, understanding colonization as simply a construct of the past, and failing to recognize the continued colonization of Indigenous people reproduces colonization itself. Verges (1999) states that postcolonial cultural psychiatrists who went to offer their services to people in the former colonies, pegged mental health dilemmas of formerly colonized people on their inability to get over a history of colonization. An article on Inuit concept of mental health, co-authored by Laurence J. Kirmayer (2008), a prominent theorist in the field of transcultural psychiatry, concludes like this:

> Clearly there are connections between this intercultural dynamic and mental health issues today [but he retracts his statement]…However it is simplistic and potentially disempowering to reduce the entirety of abuse, suicide, and suffering to a problem brought by outsiders. Certainly, current dilemmas were set in motion by contact and colonization…Exclusive focus on these extrinsic forces, though, ignores the ways in

> which communities have become caught in their own self-perpetuating cycles of social suffering. To address these internal problems, communities must take hold of their own direction and work together to create a healthy social environment (Kirmayer, Fletcher & Watt, 2008.)

This quotes illustrates the erasure of ongoing violence against Indigenous communities, and the promotion of cultural racism, which pegs the suffering of Indigenous people as "internal" to their culture and "self-perpetuated" by them. The quote also highlights that it would be simplistic to state that current problems within Indigenous groups are solely because of colonization. However, much of transcultural psychiatry does not even mention colonization beyond a short acknowledgement (Kirmayer, Fletcher, and Watt, 2008; Kirmayer, Tait, and Simpson, 2008; Kirmayer et al, 2011; van Duijl et al, 2010; Kirmayer, 2007). A similar omissions of historical analysis in transcultural psychiatry concerns the ways in which people of colour face criminalization and confinement. I will turn to this below.

Confinement of people of colour does not necessarily have to take place within the walls of prisons. People of colour have been confined within the walls of psychiatric spaces, when they have acted in ways that went against racialized conceptions of them. In her article "In Our Own Voice - African American Stories of Oppression, Survival and Recovery in Mental Health Systems," Vanessa Jackson (2003) highlights how although there have been similarities between the treatment of white and African-American people within psychiatric institutions, the ways in which African-American people came into psychiatric "care" have often been racialized (see also Summers, 2010). After the abolition of slavery in America, many "free" slaves were brought

under psychiatric care under the invention of the mental disorder, drapetomania (Jackson, 2003). Drapetomania was in essence a justification for the continued slavery of African-American people by white slave owners, as its profile predicted freed Black people to go mad (Summers, 2010). Martin Summers (2010) explains how various changing theories were used to explain why this was the case, but all of them positioned madness as essential to the nature of Black people. Arguments were made that the brains of Black people were naturally unable to function at higher levels of cognitive thinking; therefore, freedom was destructive of their sanity (Summers, 2010, p. 89). Other theories propagated that even when Black people seemed to integrate into society, they had actually just mastered the art of "mimicry" (Summers, 2010, p. 59). Another racist image of Black people that intersected with this was that they possessed the mind of children (Summers, 2010). They were unable to think for themselves and therefore, similar to the way children learn, they had to imitate the actions of the white population around them. This theory confirmed the white man in the caretaker role of the Black population, while at the same time humanizing the cruel acts of confinement against people of colour. A number of other mental disorders, such as negritude and dysaethesia aethiopica were also used to support slavery and the general domination of whites over Black and other non-white populations (Jackson, 2003).

Several of the personal stories that I came across when doing my research, suggested that people of colour continue to be brought into psychiatric care when they act out of line against racialized notions of docility and submissiveness.

> *In my first experience with any form of mental health services, an anger management counselor was assigned to me by a teacher I had often spoken out against. Thinking back, I often wonder how much my protesting against her actions went against what she thought a good Indian kid should behave like. Her constant "This is not what you're supposed to be doing" would ring at the back of my head, while it was okay for the white kids to protest, my protesting somehow offended her image of a submissive and quiet Indian girl, of which she reminded me every single one of my Indian friends in class was.*

My teacher reminded me that I was unlike my other Indian friends because I constantly spoke out against her. However the white students in the class were afforded the luxury of speaking out and being labelled as "opinionated," while I was sent to an anger management counselor. If people of colour do step out of line, they are quickly reprimanded. On the one hand, people of colour are treated as submissive and compliant; on the other hand, they are seen as dangerous and threatening when they do step "out of line."

This theme also emerges from Nirmala Erevelles' and Andrea Minear's (2010) narration of the stories of Cassie and Julius Wilson, who despite being from different time periods – Julius's story took place between the early twentieth century and ended with his death in 2001, Cassie's story took place between the early nineties and 2008 – share remarkable similarities.

Julius grew up deaf, and was charged with "lunacy" after a family friend accused him of attempting to rape his wife (Erevelles and Minear, 2010, p. 134-135). For this he was sent to the North Carolina State Hospital for the Coloured Insane, after being labelled "feeble minded" and "dangerous" (Erevelles and Minear, 2010, p. 133). He was later castrated while at the North

Carolina State Hospital for the Coloured Insane (ibid, 2010, p. 135). The heinous act was justified under the eugenics ideology, so he could become a "submissive" black man who was no longer "dangerous" (ibid, p. 135). After this, Julius was institutionalized in different ways, being released to a private farmer as a worker, and then transferred to a geriatric ward when he was labelled unfit to work (ibid, p. 135). Unfortunately Julius spent the rest of his life in mental health institutions, dying in a cottage on hospital ground in 1994 (Erevelles and Minear, 2010, p. 135).

Cassie's experience, like Julius's experience, is one that is extremely racialized. Their identity as African-Americans cannot be separated from their experience with mental health services. The defining feature of Cassie's educational years was fragmentation, as she was shifted from school to school (Erevelles and Minear, 2010, p. 135-140). She started out in an all-white elementary school, where she was eventually kicked out because of her angry outbursts (ibid, p. 135). Erevelles and Minear note that the teachers may have been unable to deal with Cassie because she was the only black student in an all white classroom, and she was automatically labelled as uncontrollable. Her first elementary school labelled her as "mentally retarded" and transferred her to Sally's Corner, a school that was supposed to provide a loving and caring environment for students with emotional and behavioral problems (ibid, p. 137). However, instead of being cared for, Cassie was locked up in what she referred to as a "jail cell" (ibid, 2010, p. 137). After being kicked out of Sally's Corner, Cassie changed schools numerous times after administrators could no longer deal with her (ibid, p. 136). When Minear (2010) met Cassie, she was in a school

where she was receiving no support for her emotional and behavioral issues, and on the brink of being kicked out (p. 136). She was getting into numerous fights with other students, and after performing oral sex on a male student within a classroom, the school was contemplating expulsion (Erevelles and Minear, 2010, p. 139).

I came across several other stories that mirror Julius's and Cassie's experience. In all of these, people of colour overstepped their boundaries by engaging in acts that challenged the views that white people held of them. For example, Pearl Johnson and Ola Mae Clemons, two Black women in the 1960s, were arrested when their actions threatened racialized notions of how Black bodies should act (Jackson, 2003). Johnson was arrested on charges of "white slavery" after she ran away from an abusive environment at the age of sixteen, and a thirteen year old white girl ran away with her (Jackson, 2003). She was sixteen at the time. Clemons was arrested after she refused to sit at the back of the bus in 1963 (Jackson, 2003). After being convicted of "white slavery" Johnson was incarcerated for a short while, but sent back home when she was found to be constantly crying, thus labelled depressed (Jackson, 2003). However, she ran away from home again, ending up on the streets once more. She went in and out of jail and various institutions and hospitals for several years of her life (Jackson, 2003). At the age of fifty one, Johnson found herself in a hospital for mental health patients after being picked up by the police while she was homeless.

> *One time I woke up and I did not have top teeth. I had top teeth but they were all broke up. I don't know if it was from shock treatments or from me gritting or whatever. But*

> *anyway, they had to pull all of my teeth out. Uhm... I've been a dope fiend (Johnson quoted in Jackson, 2003).*

Johnson received constant shock treatment but no counseling to address the sexual and physical trauma she experienced both at home and when she was moving from place to place for fifty one years (Jackson, 2003). Clemons was locked away for thirty days in prison, and then let out. Later on, when she had a "nervous breakdown" amidst a troubled marriage and the birth of a child, the same police accompanied her to Central State Hospital in Georgia (Jackson, 2003). She received continuous shock treatments during her stay there for the treatment of what was labelled paranoid schizophrenia.

> *It did help...help for a while. It makes you have an appetite. It makes you relax. It makes you forget all the problems you had. Your mind goes blank. But I would rather not take it because when my mind come back to it, I can remember my class work, my books I read. My homework...my church, my minister. But when you taken those you forget a lot of things (Jackson, 2003).*

Both Johnson and Clemons were first and foremost confined after they threatened racialized conceptions of Black women, and challenged their own subjugation by taking a stance against the violence they suffered. Johnson challenged the idea of the white caretaker by taking a white child under her wing, and Clemons refused to sit at the back of the bus asserting herself as equal to white people. Not only were both these women criminalized for behaving in a way which threatened white superiority, the criminalization added to their emotional distress and reproduced violence against their bodies, of which they were already suffering. Later on, both of them were confined to psychiatric spaces and subjected to shock treatment, a common treatment historically

used against women to subdue them (Burstow, 2006). Shock treatment can leave severe emotional and physical scars on those who receive it, and its effects can be long-lasting (Burstow, 2006). Both Pearl and Ola became "disabled because of" their institutionalization within psychiatric spaces, and both of their lives were changed forever.

Pemina Yellow Bird (n.d.), a First Nations author, reminds us that confinement of Indigenous people inside the walls of psychiatric institutions was also a part of the institutionalization of First Nations people. However, there are several distinct ways through which First Nations people came to occupy these institutions. The Hiawatha Institute was located in South Dakota within the United States, and operated for half a century, between the start of the twentieth century to the mid twentieth century (Yellow Bird, n.d.). First Nations people from across America were forcibly brought to the asylum under the label of "insane" or "mentally ill" (ibid, p. 4). However, many First Nations people who were labelled "insane" were there because they refused to obey colonial authority, whether it was a schoolteacher or reserve officer (ibid). Others were there because they refused to give up their "ceremonial and spiritual ways of life" (ibid, p. 5). Even within the institution walls, "patients" were punished for singing, dancing, praying or partaking in any spiritual ceremonies together (ibid, p. 8). Other First Nations people, who had physical ailments such as tuberculosis or epilepsy, were also brought to the institution under the label of being "mad" (ibid., p. 6). The institution served to further the cultural genocide of First Nations people within the United States. Their placement in an institution would conceal their difference, which was conceived as threatening and unlikeable to white settlers who had overtaken their lands. In addition, the justification for confinement could also be based on

arbitrarily assigning the label of "mad" to First Nations people who were not even able to speak English (Yellow Bird, n.d.). The confinement within the institution walls was a representation of the colonial project going on outside of the walls of the institution in which cultural and physical genocide was being committed. First Nations people were labelled "mentally ill" because they posed a contrast to an imagined ideal of white society, and they threatened to hinder the progression of society through their commitment to their own way of life (ibid). Indigenous people were being brought to the Hiawatha Institute through colonial institutions, such as residential schools and reserves which already functioned to control them. Yellow Bird (n.d.) highlights the displacement from one colonial institution to another colonial institution in order to better control colonized populations. Those who were more uncontrollable because they refused to conform to the standard set out for them by colonial authorities were sent to the Hiawatha Institute (ibid). Psychiatric institutions specifically designated for people of colour were not only limited to First Nations people. There were several hospitals that were solely for people of colour, as Vanessa Jackson (n.d.) and a team of people of colour recently discovered after knowledge of them had been lost in piles of institutional records.

In her article "Separate and Unequal: The Legacy of Racially Segregated Psychiatric Hospitals A Cultural Competence Training Tool" Jackson (n.d.) examines and reconstructs what happened inside the walls of long forgotten institutions for people of colour. Jackson attempts to shed light and bring forth a history that has been erased. She quotes Doria Roberts, a Black singer and songwriters, who is also an activist, in order to highlight the importance of her project.

> *Restoration is what I need, someone to scrape and chip until I bleed. And when my pictures starts to fade and crack paint it all back, paint it all back, paint it all back (Roberts quoted in Jackson, n.d., p. 9).*

Jackson's (n.d.) research uncovered six segregated facilities for people of colour who were labelled insane, three of which she was completely unaware of before her research into what she describes as "ghost web pages" and long stored away documents in hospital records (p. 9). The six hospitals she discovered in her research were: Central State Hospital in Petersburg, Virginia; State Hospital in Goldsboro, North Carolina; Mount Vernon Hospital in Mount Vernon, Alabama; Crownsville State Hospital in Crownsville, Maryland; the South Carolina State Hospital also known as the Palmetto State House; The Laki State Hospital for Coloured Insane; and the Taft Hospital (Jackson, n.d.).

Jackson's (n.d.) research found that within these hospitals, people of colour were segregated from white patients. Central State Hospital in Petersburg was a hospital completely for people of colour who were labelled insane (Jackson, n.d.). There were many commonalities between each of the hospitals, the biggest being the lack of people of colour as staff (Jackson, n.d.). When people of colour were hired, they were often hired as aides even if they had been educated as nurses (Jackson, n.d.). For example, at Crownsville State Hospital in Maryland, Sarah Maddox was the first African-American aide to be hired in 1952 since the hospital had opened in 1911 (Jackson, n.d.). Sarah recounts an incident of daily racism she faced in the workplace, when she went to go help an African American woman who was a "patient" at the institution:

> *When I came back [from nursing school], I was a licensed, an LPN, and I had my cap and gown on and everything. A lot of these people [white staff] were not qualified; they wore nursing caps but they were not nurses. I was making rounds on the infirmary and a patient asked for a nurse. So I went over to her and said, I'm a nurse. She said, I want a real nurse. Don't you dare put your Black hands on me (Maddox quoted in Jackson, n.d., p. 22).*

The "patients" of these hospitals had come to internalize racist notions that only white nurses or doctors were justified and qualified to treat "patients" (Jackson, n.d., p. 22). Despite holding a degree in nursing, Sarah Maddox was asked by a patient of colour to not touch her, as she did not see Sarah as a legitimate authority figure (Jackson, n.d.). Jackson (n.d.) also found that most of the staff of colour in the hospital who were qualified and educated with a nursing degree were pressured to take on cleaning and other caretaker roles (ibid, p. 23). Often, staff of colour were limited to doing "menial" work, and had limited interaction with patients (Jackson, n.d., p. 23). The system was set up to degrade the work of staff of colour, and to relegate them to roles where they served their white counterparts. In this way, people of colour who were brought to these "treatment" centers were forced to interact and give control to white people (who did not experience systematic racism as they did) in order to receive this so called "treatment" (Jackson, n.d.). Moreover, this "treatment" was not optional as the state or local authorities had ordered them to be there (Jackson, n.d., p. 24).

Another common theme was the treatment of people of colour who were brought to these facilities. Although the medical treatment between white and people of colour "patients" seemed

to be similar, people of colour often received these treatments in larger numbers (Jackson, n.d.). Shock therapy, periods of isolation, and use of tranquilizers was administered to "patients" of colour more than their white counterparts (Jackson, n.d.). Leasing out patients to do manual labor on farms, especially cotton fields, or to do other manual labor in both the private and public sectors, was more common for people of colour who were at the hospital (Jackson, n.d.). They were also leased out for longer periods of time. In fact, leasing out people of colour who were labelled insane, was also a common practice in colonial Africa (Jackson, n.d.). The rationale behind it was that people of colour were not able to do any type of work that required "high cognitive thinking" (Keller, 2007, p. 52). Therefore, they were best fit to do manual labour, which would keep them occupied and deter them from acting out on their impulses (Summers, 2010; Keller, 2007). It was also thought that this itself was a treatment, because if freedom had driven people of colour "insane" then putting them back to work under the white man would solve their "manic" impulses (Keller, 2007).

Confinement and criminalization of mental illness in people of colour is still a part of the ongoing colonial project that seeks to subjugate people of colour under the control of white Western institutions. Within these contexts, disability and race are not distinct categories but inform each other. Borrowing from Gorman, it cannot easily be ascertained how far people of colour became "disabled because of" disablement they faced through different institutions or if

they were "already disabled" due to their race (Gorman, 2013)[5]. Erevelles and Minear (2010) argue that race and disability have to be understood as mutually coexisting in order to challenge the current critical disability scholarship that has rooted its work in identity based social movements, which argue for the rights of people with disabilities. From the postcolonial literature that I covered above, we can understand that race and disability have always been mutually co-constitutive, and that ways of dealing with the "health" of colonized populations was informed by racialized narratives about their bodies. Furthermore, I have shown how colonial systems of psychiatric medicine created knowledges of the deficient and inferior minds of colonized people (Levine, 2003; Spurr, 1994; Keevak, 2011; Griffiths, 2002; Rogers, 2010; Abel, 2010). This forces us to further historicize psychiatric spaces as spaces of confinement under the colonial regime. Nadia Kanani (n.d.) points out that there is a lack of literature within academic scholarship that addresses these spaces of confinement, whether a prison cell or a psychiatric institution, which function to produce or reproduce disability within people of colour. Furthermore, these spaces of confinement have their roots in colonial understandings of how to deal with "mad" people of colour, which primarily included confining them without offering them any kind of treatment (Kanani, forthcoming.; Yellow Bird, n.d.). It is important to understand how these spaces function as sites for the creation of disability, especially emotional distress within people of colour, and how bodies of colour were conceptualized within them.

[5] Here I am putting a spin on Gorman's concept of "disabled already" by arguing that people of colour are "disabled already" because of their race, and are further disabled through coming into contact with racist institutions. This is to argue that people of colour from could fit into both categories simultaneously because of their race.

"Madness" in people of colour was viewed as inevitable when people of colour "betrayed" their own natural disposition of simple mindedness, docility and submission (Jackson, 2003; Summer, 2010). Therefore, confining people of colour, and subjecting them to do tasks such as agricultural farming seemed to not only return people of colour back to their "natural" state, but also illustrates that treatment centers were spaces of confinement and treatment for people of colour was not at the center of these institutions (Summers, 2010; Keller, 2007). This violent history of institutional confinement is ignored by transcultural psychiatric literature, an erasure that reproduces violence against people of colour.

Transcultural psychiatry texts discuss a range of mental health issues, including topics such as immigrant and refugee mental health, somatization, and trauma. The absence in this literature of references to psychiatric confinement under the colonial period and the continuation of this confinement within such institutions like the criminal justice system serves to reproduce a narrative that continues the violence against bodies of colour and to erase differences between people of colour and their white counterparts. Several of the transcultural psychiatric texts on immigrant and refugee mental health that were on the curriculum at McGill did not even mention histories of colonization (Fazel, Wheeler, and Danesh, 2005; Rouseau and Jamil, 2010; Steel et al, 2009; Kirmayer, Fletcher, Watt, 2008). Transcultural psychiatric texts frequently highlight that refugees from postcolonial states suffer from higher amounts of post-traumatic stress disorder, without however addressing the colonial histories of these postcolonial states (Fazel, Wheeler, and Danesh, 2005). By failing to contextualize this history, transcultural psychiatry again perpetuates a narrative which invisibilizes and the history of confinement that people of

colour have suffered. This history and the contemporary forms of violence against people of colour are interlinked, and cannot be viewed as separate if we are to understand the continuation of disabling practices against people of colour. For example, when speaking about mental health issues in immigrants, transcultural psychiatric literature does not acknowledge the ways in which immigrants continue to face discrimination and everyday forms of violence, and thereby ignores the contemporary ways in which the colonial project continues until today (Rousseau and Jamil, 2010; Goodman, Patel, and Leon, 2008; Littlewood and Lipsedge, 2005). For example, in an article by psychiatrists Rousseau and Jamil (2010) on how Muslim parents transmit information about the attacks of 9/11 to their children, the authors come to the conclusion that parents avoid discussing such issues with their kids. This in turn causes the children of these parents to develop feelings of helplessness and fear. However, the authors do not discuss why these parents, as Muslims, were silent about 9/11 with their kids. The violence against Muslim people and the unlawful confinement of Muslim-American citizens has been very well documented. Suggesting that parents simply do not want to talk about it thus ignores this context of anti-Muslim racism (See Haque, 2010; Conway, 2010; Razack, 2008; Mamdani, 2002).

Even literature that acknowledges the criminalization of people of colour with mental illness lacks an understanding of the history of confinement of people of colour, and of the ways in which the prison system reproduces that history. A famous transcultural psychiatric text by Roland Littlewood and Maurice Lipsedge (2005), titled Aliens and Alienists illustrates this. The book uses postcolonial theory to shed light on the inability of psychiatrists to understand different cultural contexts would aid in understanding how patients of colour conceptualize their

own distress. The authors touch on the criminalization of Black men in Britain, and discuss how police officers are unable to understand why they are distressed and hence take them into custody for being violent. They narrate the story of a man who believes in Rastafarianism and has the police called on him by his neighbours because of his erratic behaviour. The police were unable to understand why he was talking to himself and why he refused to obey orders, and took him into their custody. However, Littlewood and Lipsedge simply brush off his confinement through the criminal justice system as the inability of the Western world to understand how immigrants to the West conceptualize mental distress. What this does is dismiss the history of confinement of people of colour, and the racialized narratives that the act of taking someone into custody reproduces. Depicting men of colour as angry and out of control is a racialized narrative through which men of colour like Julius Wilson, discussed above, have been brought into psychiatric care (Erevelles and Minear, 2010). The act of confinement is thus not simply a misunderstanding on the part of the authorities of the mental distress in non-white people. Therefore, an analysis of colonial history and its continuities must be addressed in order to highlight the ways in which people of colour still face violence at the hands of societal institutions. Simultaneously, the idea that explanations of cultural difference are the reason why people of colour come into psychiatric care, or find little success within psychiatric systems, must be challenged.

Silence

The silence of transcultural psychiatry about historical and contemporary violence against people of colour resonates with a further theme that emerged from the personal stories examined for this

paper, that of silence. Many authors of colour wrote that when they attempted to seek care through mental health systems for the mental distress which they were suffering, their suffering was not even acknowledged.

> *I remember in my own experience, the first time I walked into my therapist's office. I was nervous it would turn out like my other experiences with therapists in my undergraduate career, who offered me all sorts of medicines as opposed to actually talking to me. However my therapist seemed kind, asked for my name, attempted to make me feel comfortable. She then asked me why I was here, at first there was nothing but silence between us, but I slowly opened up. By the end of my session I had told her so much about myself, my family, things I had never told other people. I broke down in front of her. She offered me a tissue, and said "I am sorry your mother didn't understand you. If you were my daughter I would have tried to understand." Suddenly, my momentary relief felt like a betrayal, and I was completely overtaken by guilt. I felt guilty and saddened that I had talked on and on, and she never said a word to me; guilty that I put my family, my mother up for display. I felt guilty that she thought she could judge them and guilty that she thought she had the right to. Every one of my sessions that followed, we would consist of me talking for the sake of talking. Mary would jot down notes, and occasionally recommend a book or two. My therapist never had a conversation in which she was not ferociously jotting down every word I said, and eventually, though probably not by her intention, she was successful in shutting me up completely.*

My story resonates with another one by Aretha Faye Marbley, a social worker and academic, whose work focuses on racism and the racialization of people of colour within mental health systems. Sharing her own experience with the mental health system, Marble discusses how the therapist offered no response to her after she had divulged her inner most secrets. Upon entering her first appointment with a therapist at the counseling center at her college, she recalls that members of her family had already had experience with mental health institutions.

> *No one in my family has ever seen a mental health professional, unless you include my eldest sister, who, in 1968 at age 24, was confined to a mentally ill ward in Cook County Hospital on the west side of Chicago with a diagnosis of paranoid schizophrenia, and Mama (my Aunt Johnnie), who, was 40 years earlier in 1928, from ages 20 to 24, was confined to what was then referred to as a lunatic asylum with a diagnosis of crazy...my sister had extensive and massive shock treatments, and my mama was caged and treated like a wild animal and watered down with hoses for more than 4 years (Marbley, 2011, preface).*

Marble remembers her hands "trembling" as she entered the office of the therapist, afraid of what would happen next. Fifty minutes afterwards her first session ended as it had began, in complete silence.

> *An old white man stood up from behind a black reclining chair, took a cigar out of his mouth with his right hand, motioned with his left hand to take a seat...Strangely, he did not ask for my name or what brought me to counseling, just staring at me with steel blue eyes. I waited for what seemed like 5 minutes before giving him my name. We sat another 5 minutes in silence...As words rushed out, and I spilled my guts and told family secrets*

to a complete stranger, he said nothing, not a damn thing. He never even acknowledged that I was there, not that I was human. Exactly 50 minutes later, he stood up and said, 'Your time is up.' I stood up at once, feeling invisible and broken inside from this inhuman experience. (Marbley, 2011, preface).

I found another similar story in a blog post on a tumblr.com blog titled "I'm A Struggling POC". This website allows people of colour to share their experiences with the mental health system with other people of colour. Many of the stories or messages were about self love and self care, encouraging other people of colour to put themselves first, and find it in themselves to overcome issues with their mental health. Many blog entries expressed disinterest in the process of therapy because of their own experiences, or experiences of people of colour around them. An anonymous women of colour posted her experience about a college counsellor who she went to see in a time of great distress. Unfortunately, her experience was so negative that she decided to turn away from the process of therapy.

I had a really bad experience with the counselor at my college, too. I was suicidal without a very specific plan - but I literally thought about it all the time. Walking down the stairs, I thought that I could jump. Walking down the street, I thought that I could throw myself in front of a car. Things like that. Death and how to die preoccupied my mind... One day, I went into my appointment with my school counselor. I quite literally said to her, 'I want to kill myself. I don't have a plan just yet, but as soon as I have one, I will go through with it. I am going to kill myself.' She looked at me, brows furrowed, and didn't say anything. After a few moments, she finally went, 'Hmm. That must be really hard.'... Really? No shit, Sherlock. I'm struggling with wanting to be alive, am

> *continuously finding ways to take it away, and you're telling me that it must be 'hard?'...Therapy is a really, really tricky thing. I've had five different therapists over the last six years. All of them have been white women who could understand some of my issues related to feminism and being a woman, but no one could truly understand the POC part (Anonymous, Wall of Stories, February 2014).*

The stories above invoke the images of racialized bodies as a performance piece. The "patient" of colour is expected to play out the ways in which they express mental distress, and the therapist, consumes the patient as an object of study (Griffiths, 2002; Maxwell, 1999). Expressing emotional distress to an authority can be a very nerve wracking experience, as it was in my case, and in the case of Aretha Faye, whose own family had gone through psychiatric trauma (Marbley, 2011, preface). When you finally make the decision to open up, silence can be an utterly humiliating and dehumanizing response. My therapist often asked "So what should we discuss today?" and encouraged me to open up about my issues. However, whenever she responded with silence I felt as if I had just done an entire theatrical performance – tears and all – that emitted a very apathetic response from the audience (my therapist). My tears, my fears, and the fact I had not only put myself but my family as an object of display to be studied, meant nothing to this woman.

Silence does not only happen within the confines of the office of counselors or psychiatrists, it also happens when people of colour attempt to access other kinds of mental health services, and find that there is no response on the part of the institution that is supposed to schedule them in.

One blog poster states that after experiencing feelings of depression she decided to schedule an appointment with a counselor inside the hospital. However, the administrative staff at the hospital was not responsive to her concerns when she asked to see a counselor. She ended up giving up on trying to contact the hospital for help, and decided that it was better for her to just take care of herself.

> *I'm the anon no one would call back. I was supposed to have my first session today and I called ahead to confirm the time because I'd have to walk most of the way there. The weather's in flux right now so these things take planing, ya know? The secretary claimed we never spoke, but I had the times and dates we talked because we had to reschedule several times... Now the schedule is so tight that I can't be seen today or any time soon. She tried to reschedule me over a month away for a day I'd already said I couldn't do because of work. The work that makes me able to have the insurance for these appointments. The work that is almost totally inflexible when it comes to time off... Maybe PoC don't get diagnosed or treated at the rates we should because we get tired of jumping hoops trying to get an opportunity to a foot in the lobby? I understand that mental services are hard to come by. At the same time, I have to wonder if I would've told them "I'm going to kill myself if I don't see someone right now" if I'd be in treatment already. Assuming they even believed me because suicide is something PoC supposedly "don't do." I feel like being honest about my situation—which is what you're supposed to do for the process to even be effective—hasn't helped me at all...I was hopeful about therapy and the road to wellness but no longer. I'll just take care of myself. As always. Strong Black women (and strong PoC, for that matter) aren't born:*

> *we're made by bad experiences, tempered by the knowledge that we're on our own and its up to us to survive, and grounded by the support of the others like us (if we can get to them) because they understand [other entries on this particular Tumblr also affirmed similar responses of apathy from administration when people of colour attempted to contact for help.] (Anonymous, Wall of Stories, forthcoming).*

Silence in the room, sitting across a therapist, or silence when attempting to access mental health services: These themes again resonate with the ways in which the voices of people of colour are silenced within the literature of transcultural psychiatry. This silencing functions very much like silence of the therapist who simply records what is being said, and offers nothing in response when people of colour reveal themselves to be emotionally distressed. Many works within transcultural psychiatry, especially those that focus on isolated tribal groups of colour, or First Nation groups within North America, read to me like an anthropological ethnographic film in which a narrator monotonously described the daily activities of a certain tribe of people, and what significance these held for them (See, van Duijl et al, 2010; Seligman and Kirmayer, 2008; Kirmayer, Fletcher, and Watt, 2008; Kirmayer et al, 2011; Kirmayer and Jarvis, 2005; Mesquita and Walker, 2003; Kitayama and Park, 2007). Medical scripts are written in a similar way, in that the doctor writes down the symptoms described by the patient, and prescribes a prognosis (Good, 1994). In fact, medical students are trained in medical school in how to take notes during their clinical rotations, and are taught to discard information that does not pertain to the biological prognosis of the disease (Good, 1994). Literature within transcultural psychiatry is reflective of the biomedical model from which it has developed, and the scientific positivism

which it aligns itself with (Littlewood and Lipsedge, 2005). The note taking method taught to medical students is meant to reflect the scientific nature of the medical discipline, in which students "objectively" take notes of what is being said and present their final prognosis based on the symptoms recorded (Good, 1994).

Similarly, transcultural psychiatric texts treat bodies of colour like ethnographic cases that they must record. They often contain descriptions of what certain "ceremonies" mean in relation to mental health concepts within that community. This is related to the idea of consuming bodies of colour as objects of study, but in a specific way that racializes bodies of colour as irrational. One prominent image that recurs in transcultural psychiatric texts is that of a person of colour who is believed to be possessed by a spirit, and how the community attempts to rid the possessed person of the spirit (Seligman and Kirmayer, 2008; van Duijl et al, 2010; Kirmayer, 1989; Kirmayer, 2004). Transcultural psychiatry records these moments as a medical doctor would record the symptoms of a patient, as a silent observer who is simply relaying what is being seen, thus aligning itself with science and objectivity. However, unlike medical reports, what is being recorded here is not a list of symptoms which the patient is describing, but the lived reality of communities of colour. In an article outlining how the psychoanalytic concepts of disassociation apply to possession in Tojara, Indonesia, the *ma'maro* ritual is described as the follows:

> The *ma'maro* ritual in Tana Toraja, Indonesia is a possession ritual that is primarily concerned with furthering the prospects of wealth and prosperity and with avoiding illness and misfortune…It does so by encouraging powerful spirits of the upperworld, earth, and lowerworld, called *deata,* to enter the village…it is the chanting of paired verse

> called *gelong* that actually herald the entrance of spirits into the village. *Gelong* are accompanied by the driving beat of a drum and are performed while participants hold hands and dance…images of heat and fire, and of dissolution, disorder, and transformation are prominent in the *ma'maro* ritual (Hollan, 2000, p.546-548).

These lived realities are thus recorded in a manner which favours a superficial understanding, and promotes an idea of essential difference between the Indigenous culture and the normalized culture of the white western world. In other words, transcultural psychiatric texts promote the listing and description of difference as their primary methodology. Although Hollan (2000) acknowledges that the *ma'maro* ritual is way to reconnect with community, and should not be understood as mental illness, he still argues that it warrants study. In fact, his description takes up a large portion of his article, including references to another article written by him that describes the ceremony even more extensively. A similar representation emerges from an article written by Rebecca Lester, an anthropologist and feminist who writes transcultural psychiatric literature. Lester tells the story of a Mexican nun named Celeste, who "confides" in her about communicating with God.

> I developed close relationships with many of the postulants, but none more than Celeste. I was drawn to Celeste's dark and sarcastic sense of humor…Perhaps it was because of this trust, and the fact that I was an outsider in the convent, that Celeste confided her secret to me that winter…Sometimes, she said, she felt herself communicating with God during these episodes…In psychiatric terms, the experiences Celeste describes could be considered dissociative…These sorts of dissociative disorders are generally though to result from extreme physical of psychological trauma…In many ways, Celeste is an

> unusual case. Most strikingly, her capacity for self-reflection and her ability to self-consciously articulate her experiences through various explanatory frames marks her as uncommon (Lester, 2008, p. 57-70).

We can see the initial colonial intrigue with the object of study as Lester is "drawn" to "Celeste's dark and sarcastic humor." Lester's entire article details how Celeste attempts to understand her experience through a variety of explanations; psychological, spiritual or caused by childhood trauma. Lester finds this unusual, but relies on the explanation that favours a psychiatric understanding of her experience, specifically dissociation. We can see once more that the style of writing, that is supposedly just an observation of the events unfolding before the psychiatrist's eyes, actually favours the silence of the person of colour, and an understanding which pins western psychiatric understandings of experiences as superior; even if that goes unsaid. In an article exploring the concept of *jinn* (unseen spirits in the Islamic tradition) within a group of East London Bangladeshis, the authors explain the relationship between *jinn* and Bangladeshi Londoners as such:

> All Muslims are obligated to believe in the existence of *jinn* (spirits.)…Our younger informants regularly pointed out how invocation of *jinn* explanations was common among the elderly and relatively less educated…Bangladeshi Islam is highly influenced by Sufism and emphasizes the cult of *pirs*- Muslim holy men, saints who are held to have the ability to perform 'miracles.'…However, unlike humans, they [the *jinn*] have extraordinary powers to take on different shapes such as the ability to take on the forms of birds, animals and even humans…They are said to occupy dark places, graveyards and

> other polluted places…Most Islamic scholars accept that *jinn* can possess people…Common problems where *jinn* were implicated included sudden changes in behaviour, a condition that resembles the western notion of 'depression' (Dein, Alexander and Napier, 2008, p.32-38).

Dein, Alexander and Napier go on to then describe stories of Bangladeshi Londoners who have held *jinn* responsible for their experiences. They describe Rashida, a 56 year old woman who held *jinn* responsible for her chest pain and anguish, however they highlight that Rashida refused to cooperate with counseling because she would not address her mistrust of authority (ibid, p. 39). They also explain how traditional healers are accessed by Bangladeshi people who believe they are being possessed or visited by *jinn* (ibid, p. 40, 48). In this article we again see the assertion of western superiority, not only through the focus on different beliefs within the Bangladeshi community but also through highlighting the beliefs of the younger, British born, Bangladeshi youth. The younger British born Bangladeshi youth, who do not seem to believe in possessions by *jinn*, and in visiting saintly men for help, come to represent modernity. Inevitably though, by highlighting the different beliefs of the elder population, the authors assert white western superiority in understanding these experiences.

To sum this theme up, people of colour are used as an accessory to reproduce an understanding of how Western biomedicine, in particular transcultural psychiatry, views different conceptions of mental distress. Their mention is usually limited to observations of their behaviour, which do not include how they view their own experiences. The absence of voices of colour thus serves to reproduce the silencing of people of colour in psychiatry, including in the field of transcultural

psychiatry which commits itself to a biomedical understanding of illness and culture in order to legitimize itself. In this genre that favours a Western style of prognosis, the personal stories of people of colour are not needed.

Violence in Institutions Connected to Mental Health

The last theme dealing with the erasure of violence within mental health systems is the dismissal in mental health institutions of mental distress in people of colour. People of colour suffering from mental distress felt dismissed by organizations that were unable to contextualize their mental distress as a product of everyday discrimination and hardships.

Several of the stories by people of colour stressed the ways in which academic institutions were complicit in producing large amounts of stress and isolation for academics of colour, and failed to provide adequate mental health services which addressed their issues. Students of colour felt racialized within university classrooms, and could see the differential treatment they were receiving from professors compared to their white counterparts. Erin "Mari" Morales-Williams, a doctoral student at Temple University, writes about her experience of past sexual abuse, which led to depression during her doctoral degree, and the difficulty of receiving help from medical institutions. Erin's experience of her doctoral education fed her depression and anxiety, where she felt marginalized by the academic institution of which she was a part.

> But graduate school, like all of my other schools, was a colonial experience, and I realized in graduate school how colonized I still was. I still believed that those who dominated conversation were the smartest, that my intelligence was validated by my

> professor's compliments; that if I couldn't bring something new to the conversation or anything at all, that I might as well not be there. As an intellectually gifted coloured girl, most of the white privatized institutions I attended held me to high expectations and offered little to no positive reinforcement. Receiving less love and attention than my white counterparts, my academic accomplishments never felt enough... The colonial experience, if not resisted, will always make one feel as if we are not enough; it will always push us to the margins until we can't breathe, or read or write or create, or feel entitled to the right to be wrong (Morales-Williams, para. 1-20, 2012).

Her experience within the academic field, where she was continually silenced, reached a point where she eventually had a panic attack that resulted in her hospitalization. When she reached triage, she explained to a nurse the events leading up to her panic attack, and how she felt when listening to her non-POC classmates speak about urban school reform. The nurse's response was very dismissive of her problems, "You don't have blood clot, you just need doctor for the head, you just like, a little crazy" (Morales-Williams, para. 4, 2012). Erin's concerns were dismissed by subjecting her to the label of "crazy". Her behavior as a marginalized academic of colour continuously struggling to find herself in a racist and marginalizing system was considered exceptional. What became invisibilized was the everyday struggle that people of colour face in systems that perpetuate racism, create emotional distress for them, and fail to acknowledge this production of disability (Kanani, forthcoming; Ware, Ruzsa, and Dias, 2014; Meekosha, 2011; Erevelles, 2010). Interestingly enough, although institutions constantly reference their clients to each other, often times – as illustrated in the story above – they also draw out domains on how to regulate bodies of colour. The academic institution does not concern itself with mental distress

caused by experiences of racism within it, because that is relegated to the domain of mental health workers. In this way, the academic institution conforms to the ideology that racism is a product of individual perceptions about race, and mental health problems arise when individuals are unable to reconcile that stress within themselves.

Shannon Gibney and her co-author (2014), who chose to remain anonymous, wrote about their treatment of them by the educational institution in which they taught on an activist site called FeministWire.. The following occurred after highlighted that the English courses at their college were predominantly focused on white male authors.

> But late at night, lying in my bed, considering a colleague's blithe dismissal of my critical analysis of the whitening of our students' journey through the Western arc of our college-level English courses, I realize that perhaps I am not really there. As a woman of colour, even after a decade in the 21st century, I am rendered invisible... After all, the only places where we feel seen at academic institution are in the classroom with our students and in the offices and company of the handful of other women of colour faculty and white allies. Once we step outside of these too few safe and comforting spaces, we never know what we will find, and if we are even more honest with ourselves, what we usually find are processes, policies, and procedures that work to the detriment of our intellectual, emotional, and physical health as women of colour faculty...We don't have the privilege of being silent, and are also cognizant that we would not be where we are, were it not for folks who spoke up in our interests in the past... One of us [Gibney] was accused of racial harassment from an angry white male student [who felt offended as a

> white male by Gibney's lecture on structural racism], and was required to undergo an investigative process facilitated by the institution's lawyer because we dared to challenge the history of racial violence and its correlation to silencing the voice of "The Other" during a journalism course . Later, a white male adjunct, angry that he was not selected for a tenure-track position, filed a claim of racial harassment against one of us, which the college's Legal Affairs department turned into a full-scale investigation …Furthermore, one of us was told by our immediate superior that we are "unprofessional," that we have a problem with "civility and collegiality," and that we should correct this if we want to assure our tenure (Gibney and Anonymous, 2014, section 1-4).

Gibney and her co-author were subjected to these accusations and investigations for seven years, yet they could not turn to mental health services within that system, because this would have labeled them as "insane" and unfit to teach in the eyes of the institution.

> We come to an institution where whiteness is very much still centered, in terms of pedagogy, where the students who look like you are treated like sloppy seconds, and the ones who don't are treated like 'the real thing.' We are in a space where Black female bodies are routinely disciplined by lawyers, managers, students, and colleagues, for daring to be unapologetically Black and female at the same time (Gibney and Anonymous, section 6, 2012).

Shanesha Brooks-Tatum, another academic woman of colour, also found that racism and sexism within the academic institution were taking a toll on her mental health. Echoing Gibney and her co-author, she states that she was unable to find mental health resources within academic

institutions. In conversation with another friend who was starting a doctoral program, she discusses the challenges that black women face within academia, and the mental health issues that arise from it. Brooks-Tatum puts it as follows, "The health issues that black women face are understandable, though not acceptable, when we understand the confounded stress associated with daily encounters with racism, sexism, and heterosexism" (Brooks-Tatum, 2012, para. 1-6). Black women in academia are not merely women under stress from academic workloads, but women of colour facing racism and sexism. Race and gender thus come together to create situations where mental health problems are continually produced. Brooks-Tatum thus echoes what others have stated:

> Self-care is "an act of political warfare" not only because the personal is indeed political, but because when black women take care of themselves, they challenge the myth of the superwoman (Michele Wallace) and simultaneously challenge structures of oppression that praise black women for being the perpetual "mules of the world" (Zora Neale Hurston). And ultimately, to take care of ourselves is to treasure ourselves, and ensure that we'll have the longevity to continue our activist work against racism, sexism, heterosexism, and other "-isms" that attempt to circumscribe and control bodies in this world (Brooks-Tatum, para.7 , 2012).

The stories of Gibney, her co-author, and Brooks-Tatum highlight that mental health issues, especially among people of colour, are understood to be problems of the individual, and not problems of the institution. However, under colonialism, academic institutions played a large part in sustaining the colonial empire by producing research that justified hierarchies between white and non-white populations (Griffiths, 2002; Maxwell, 1999; Rogers, 2010). Academics

also organized the world fairs and the travelling shows in order to showcase the research they were doing. This not only worked to showcase the difference between European and non-European bodies to a large scale of people, it also aided in garnering public support for the mission of various European empires (Griffiths, 2002; Maxwell, 1999). By dismissing the concerns of racialized people within the education system, the education system invisibilizes its role as both a producer of disablement within people of colour; and as an institution that once served the colonial empire through the production of the colonial narrative of difference.

Two other stories that illustrate the ways in which institutions connected to mental health are also producers of mental health themselves, are the stories of Ingles Sigue and an anonymous poster, who published their stories to Poor Magazine. Poor Magazine is an online activist magazine that advocates on behalf of Indigenous groups, and people who suffer from poverty. Ingles Sigue, and the anonymous poster were both mothers who explained the ways in which the lack of institutional support and discrimination faced by them as women of colour contributed to emotional distress in their lives. Ingles Sigue has been homeless "on and off since 1992" after leaving home following a fight with her parents. In the context of poverty, Ingles soon found herself addicted to drugs and does not "really remember much from 1992 to 1995... [but she attempted to make some changes and] returned to college in 1997, but it only lasted a year." After reconciling with her parents, Ingles moved back to El Paso, and found a job as a telephone operator, but quickly fell back into depression. After an anonymous caller lodged a complaint against her for leaving her child alone and not feeding her, she was charged with child endangerment. Her parents testified against her during the trial, and agreed she was not fit to

raise her child because of her mental illness. In an attempt to get help for her depression, she turned to CPS [Child Protective Services] for help with obtaining mental health services, however they refused to assist her. Ingles then moved into a small apartment with her boyfriend Todd, with the help of the school. Soon after Todd began to suffer from a disability and was bedridden, but CPS decided – against Ingles's wishes – that it was okay for the child to be back with her mother in these conditions. Eventually Ingles was again charged with child endangerment. This time they took away her daughter, who she is yet to be reunited with (Tiny, 2011, para. 1-18).

Another mother of colour shares a similar story to Ingles, in which she felt completely powerless as a poor woman of colour suffering from poverty and suffered from mental breakdowns. She recalls one day when she was riding the bus,

> He [her son] had just eaten, been changed and had his nap. In other words, I had done everything I could to make him happy and healthy, but on his journey from the Tenderloin to the wealthy area of Nob Hill where the supermarket lived where I was able to get his lactose-free milk with my WIC check- his unspecified crying almost caused me to lose it. I am not sure what that would have looked like or what I would have actually done, but I was completely overwrought, immobilized, and every time he screamed my overtired, not properly fed or housed body would quake with a lethal mixture of public humiliation and fear for my son's safety.

This mother of colour goes on to conclude that "culturally competent" mental health services are needed for Black people within the United States. She adds that the real solution to better mental

health outcomes for Black people lies in solving problems linked to poverty, such as lack of housing. Both these stories illustrate the ways in which institutional violence serves to disable people of colour, especially because institutions that regulate people below the poverty line do not assist in helping them secure mental health services. In Ingles's story in particular, it becomes clear that the CPS was not willing to assist her in seeking out mental health services for her betterment, as it was not a part of their domain.

The question how mental health institutions are creating disability in people of colour is not addressed within transcultural psychiatry. Transcultural psychiatry limits its study to how people of colour perceive institutions of care, how they perform in societal institutions such as the school system, and how they make use of Western institutions (Goodman, Patel and Leon, 2008; Rousseau and Jamil, 2010; Kirmayer et al., 2011; Kirmayer, 2012; Kirmayer et al., 2003). However, transcultural psychiatric literature does not take time to question dominant institutions themselves, and how they discriminate against people of colour. Transcultural psychiatrists will acknowledge that people of colour tend to distrust dominant societal institutions more so than their white counterparts, but the reason that mistrust exists is never deeply explored. Without accounting for how institutions are themselves a site of the production of disability for people of colour, and sometimes the reason why people of colour do not feel that they can seek out help for mental health disturbances they may be experiencing, is an indicator of how institutions can connect to produce disablement within people of colour (Kanani, forthcoming; Verges, 1999; Ware, Ruzsa and Dias, 2014) Societal institutions are rooted in the colonial narrative of difference, and sustain that difference through their practices (Verges, 1999; Khanna, 2003);

whether these practices are whitewashing academic research and silencing academics of color by reprimanding them for speaking out, or sustaining people of colour in a cycle of poverty that disables them.

The stories of people of colour explored in this chapter thus had three distinct themes: the confinement and criminalization of people of colour labelled as having a mental illness; the silencing of people of colour in mental health practices and narratives of transcultural psychiatry; and the lack of acknowledgement of how institutions that are separate (albeit related) to the mental health system function to create disablement amongst people of colour on a wider scale. The bigger thread connected each of these themes was the erasure of institutional violence (whether in the prison or academic system) and the resulting reproduction of colonial narrative which asserts white psychiatrists as having superior understandings of culture and mental distress. These personal narratives of people of colour also serve to critique transcultural psychiatry, and highlight the ways in which psychiatric institutions still continue the colonial project on people of colour. The concerns of people of colour are concerns that transcultural psychiatric literature has not yet addressed. How can transcultural psychiatry have any understanding of mental illness in people of colour when it does not address institutional violence against them.

Conclusion

Transcultural psychiatry is a discipline which grew out of, and continues to reproduce colonial narratives about people of colour. Through the continual differentiation between people of colour and white western subjects, who are rarely studied, and through erasure of discussion about ongoing violence on bodies of colour at the hands of societal institutions; transcultural psychiatry commits to continuing the legacy of colonialism which has often silenced people of colour from the narrative making process, and portrayed them as inferior and incapable of higher level cognitive functioning. The stories of people of colour brought out themes such as confinement and criminalization of those who either seek help for, or are forcibly brought into psychiatric care; the silencing of people of colour within the walls of counselling spaces; the treatment of people of colour as objects to be studied, and observed; and the ways in which societal institution connect to create stress for people of colour and produce disablement. Transcultural psychiatry seems to only commit itself to understanding culture in a superficial way, in which culture is simply a set of beliefs, that can be uncovered through observation of non-European peoples over an extended period of time. Not only does this cement culture as an unchanging entity that can be

classified and compared, it also ignores the ways in which violence and subjugation of people of colour is also a part of the cultural process. I would argue that in ignoring the specific forms of violence caused by psychiatric institutions against people of colour, transcultural psychiatry preserves itself as a discipline. In this way, transcultural psychiatry can acknowledge the colonial roots of psychiatry, without acknowledging psychiatry itself as a colonial discipline. It can freely make use of postcolonial and anthropological discourses of culture, legitimizing itself as a discipline which is showing sensitivity towards the understanding of culture; something which its colonial past may not have done. However, the underlying exploration of difference, and the classification of that difference, and the unexplored territory of white subjects as also being with culture, is a continuation of the colonial project itself. From my research within transcultural psychiatry, references are indeed made to theories put forth by postcolonial writers. However, these theories are only used to justify the existence of psychiatry as a discipline for understanding racialized peoples. Near the end of my course at McGill University, I remember how the professor ended the last class by saying, "I just want you guys to know, that we have discussed a lot, and while I think it is important to understand traditional ways of healing among different ethnic groups, in no way am I saying there is any better treatment for mental illness than through the use of medicine." It was then that I realized that psychiatry is itself an offshoot of western biomedicine, whose aim it is to understand different "ethnic groups." Unless psychiatry is willing to become a new discipline altogether, rid itself of the study of difference, and stop gazing upon the bodies of people of colour, it will always be imbued with racial discourses that assert the superiority of white western subjects over racialized peoples. Ironically, it may well be transcultural psychiatry's goal to unearth and "understand" people of colour, that

renders it a colonial discipline (Khanna 2003). People of colour are simply objects of study that add to a growing list of psychiatric disorders. Their existence in the field is dependent upon the constant unearthing of new difference (Khanna, 2003). After all, as scholars of colonialism have long taught us, the project of "understanding" has a long history of leading to classification, comparison and control

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