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**Narratives from the Mind's Eye: The
Significance of Mental Health
Pathography in New Zealand, 1980-
2008.**

A thesis
submitted in fulfilment
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Abstract

Medical narratives have dominated historical accounts of suffering, patients have also played a role in their own illness experiences. Efforts to elucidate their perspective have necessarily focused on deconstructionist readings of material produced by the medical profession. However, in recent years historians have been aided in their task by sufferers, who have begun to publish their own narratives of affliction. These accounts, called 'pathographies', are particularly significant for histories of mental health, where comprehension outside experience remains tenuous.

This thesis investigates sufferers' experiences of mental illness through an examination of fourteen New Zealand mental health pathographies, published between 1980 and 2008. It considers, not just what pathographies say, but how the way in which they say it, including the myths, language and media used, conveys the desired meaning and reflects the purpose of the narrative. Sufferers' narratives inform readers about what it is like to be ill, including what was thought, felt and done. In describing their experiences sufferers invariably discuss the illness relationships which comprise their support network. Most especially they highlight the importance of the role which family and friends play in recovery. Despite pathography's restoration of the patient's voice through the provision of a legitimate, therapeutic narrative, silences remain. Whether the result of selectivity, concealment, or forgetfulness, pathographers' silences are far from meaningless, powerfully conveying the pain, anger, embarrassment, and hurt which eludes articulation. In spite of the presence of silence this thesis argues that pathographies are a rich source of information about the position of mental illness sufferers. Yet to be fully utilised, I argue that pathographies testify to the way in which the chaotic can be ordered in a therapeutic plot which communicates the individual truth wrought by memory.

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Introduction

'Medical events' Roy Porter observes, 'have frequently been complex social rituals involving family and community as well as sufferers and physicians'.¹ Foregrounding the patient's experience is therefore imperative, he asserts, if medical history is to be freed from the major historical distortion which has plagued traditional physician-centred accounts. Indeed, the patient's perspective is especially important given that 'most maladies have not in fact been treated by the medical profession but by self- or community help, or in the paramedical marketplace where the sufferer's own initiatives, confidence, and pockets are critical'.² This observation is particularly pertinent in light of statistics which show that many people with a mental illness delay or fail to seek treatment because they wish to handle the problem on their own, or because they see the problem as remedying itself.³ Without the patient's perspective, many sufferers of mental illness would fall outside the traditional medical historical gaze; their obscurity silencing their experiences.

This thesis uses fourteen New Zealand mental health pathographies, published between 1980 and 2008, to illuminate key aspects of patients' experience of mental illness. By closely examining the construction and content of the pathographies the thesis considers their significance as a source of information about mental disorder. More broadly, it considers what they reveal about illness relationships, and what can be understood from the silences which inevitably remain. It argues that, despite the presence of silence, sufferers' narratives are richly informative about what Anne Hunsaker Hawkins terms 'the humanistic dimensions of medical enterprise', including the personal and social

¹ Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), p. 175.

² Porter, 'The Patient's View', p. 192.

³ Mark A. Oakley Browne, and J. Elisabeth Wells, '8.7: Reasons for delaying seeking help, stopping treatment or not seeking help in the past 12 months', in *Te Rau Hinengaro: The New Zealand Mental Health Survey*, edited by Mark A. Oakley Browne, J. Elisabeth Wells and Kate M. Scott (Wellington: Ministry of Health, 2006), pp. 135-36.

costs of suffering, and the consequences of treatment.⁴ Effectively silenced by dominant medical discourse, the patient's perspective has frequently been overlooked. By placing sufferers at its centre the thesis contributes a more balanced historical understanding of New Zealand's psychiatric past.

Best described as written autobiographical and biographical accounts of illness, pathography, according to Anne Hunsaker Hawkins, 'could include material from diaries and journals as well, since these are invariably edited and organized before being published as autobiographical narratives'.⁵ Pathographies do not merely catalogue the various signs and symptoms exhibited, or detail diagnoses received and treatments prescribed. They also communicate what it is like to be ill, focusing on what was thought, felt and done. Though not, strictly speaking, a pathography because it lacks a specific illness focus, Janet Frame's autobiography is a notable New Zealand example, given its dissemination into popular knowledge, of the nature of illness narratives.⁶ Like many of the pathographies which are examined in this thesis, Frame's autobiography is valuable because it informs about the consequences of illness – the physical, social and psychological ramifications of suffering.

Unsurprisingly, these consequences are frequently viewed in terms of what has been lost. Investigating the experiences of psychiatric patients in Oxfordshire, Kerry Davies identifies loss as being a key narrative frame used by psychiatric patients to express their suffering.⁷ She also identifies two other narrative 'frames': survival and self-discovery, and self as patient. Pointing to these 'frames', Davies contests the perception that patients are silent, instead asserting that 'patients have always relied on different narrative forms to have some sort of say'.⁸ In

⁴ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography*, 2nd edn. (West Lafayette, Ind.: Purdue University Press, 1999), p. xi.

⁵ Hawkins, p. xviii.

⁶ Janet Frame, *An Autobiography* (Auckland: Random Century, 1991).

⁷ Kerry Davies, "Silent and Censured Travellers'? Patients' Narratives and Patients' voices: Perspectives on the history of Mental Illness since 1948", *Social history of Medicine*, 14.2 (2001), pp. 267-292.

⁸ Davies, p. 272.

so doing, their narratives inform us, not just about the 'inner world' of mental illness, but also, Davies argues, about the 'outer world' of collective experience.⁹

Similarly, Arthur Frank has identified three types of illness narratives which he has termed restitution, chaos and quest which patients use to order their illness experiences.¹⁰ Correspondingly, Anne Hunsaker Hawkins has detailed five central reoccurring myths: battle and journey, rebirth, death, healthy mindedness, and environmental causation. Each of these writers identify and examine key narrative 'frames' which have relevance for similar investigations into the form of patients' narratives that takes place in the first chapter of this thesis.

While pathography is distinguished from traditional autobiographical narratives by its illness focus, it can, and frequently does, include autobiographical material that is chronologically distant from the main illness events described. Unlike sufferers of physical disease, pathographers of mental illness are often able to link these seemingly unconnected events, such as those of early childhood, into their narratives as a way of explaining their current affliction. However, regardless of relevance to the illness narrative, Robert Jay Lifton sees this inclusion as being a crucial part of the recovery process where sufferers re-establish a connection with their life-in-health prior to illness, thereby restoring lost continuity.¹¹ Similarly, Judith Lewis Herman sees reconnection as being of the greatest importance because 'recovery can take place only within the context of relationships; it cannot occur in isolation'.¹²

Significantly, pathography affords sufferers the opportunity to express their experiences by providing them with a legitimate 'therapeutic plot'

⁹ Davies, p. 286.

¹⁰ Arthur W. Frank, *The Wounded Storyteller: Body, Illness and Ethics* (Chicago: University of Chicago Press, 1995).

¹¹ Lifton, Robert Jay, *Death in Life: Survivors of Hiroshima* (London: Weidenfeld & Nicolson, 1968), pp. 367-386.

¹² Judith Lewis Herman, *Trauma and Recovery* (London: Pandora, 1994), p. 133.

for their suffering.¹³ Hawkins notes that 'pathographies are important human documents not only because they record a traumatic crisis that may occur to all of us but because they represent – in their very writing as well as their content – the ways these crises may be overcome, survived, and understood. Pathography describes a profoundly destructive experience; at the same time it testifies to the capacity to transform that experience in ways that heal.'¹⁴ This thesis draws upon Hawkins' work but also extends it, incorporating specific psychiatric qualifications.

In the last twenty years, New Zealand mental health historians have produced a significant body of secondary literature focused on the patient's perspective. Indicative of a growing interest in the social history of psychiatric care, this work has primarily examined nineteenth and early twentieth century asylum experiences using archived patient records. Out of this scholarship, two central themes have emerged: gender and the family. The former has seen investigations of the way in which the asylum reinforced gender roles through its treatment regime and segregation of patients, and has considered how this translated into differences between male and female experiences.¹⁵ Notably, Barbara Brookes has looked at the way women actively used the asylum as a preferable, if temporary, solution for abusive, drunken, violent, or sexually deviant husbands, brothers and sons.¹⁶ Her assertion that women used the asylum as a form of social control casts new light on perceptions of women solely as victims of institutional oppression. The family, historians have shown, played a central role in committal and

¹³ Hawkins, p. 15.

¹⁴ Hawkins, p. xix.

¹⁵ See Barbara Brookes, 'Women and Madness: A Case-study of the Seacliff Asylum, 1890-1920, in *Women in History 2: Essays on Women in New Zealand*, edited by Barbara Brookes, Charlotte Macdonald and Margaret Tennant (Wellington: Bridget Williams Books, 1992), pp. 129-147 and, 'Men and Madness in New Zealand, 1890-1916', in *New Countries and Old Medicine: Proceeding of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994*, edited by Linda Bryder and Derek A. Dow (Auckland: Pyramid Press, 1995), pp. 203-210; Bronwyn Labrum, 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26 (1992), pp. 125-44.

¹⁶ See Brookes, 'Women and Madness'.

discharge from the asylum.¹⁷ Their role in caring for ailing family members, seeking medical assistance when no longer able to cope with abnormal behaviour, and in communicating with Asylum officials following committal, especially in order to procure release has, historians argue, been significantly overlooked. Catharine Coleborne's article on the presence of emotion in asylum correspondence is especially insightful because it highlights the concern of family members for their relative which goes beyond a mere sense of duty.

While this research into aspects of gender and the role of family has produced a number of valuable insights, a scarcity of more recent patient perspectives has been a limitation of the existing scholarship. Two recent works have shown ways in which more modern perspectives can be sought. Rob Smith uses Janet Frame's novel *Faces in the Water* to consider the significance of language for patients. Drawing on the ideas of Michel Foucault, Smith argues that Language is used to silence and control psychiatric patients, most especially through their being labelled as mentally ill.¹⁸ The other work is Alison Hunt's essay on the use of autobiography as psychiatric treatment.¹⁹ Hunt highlights the brief, foray by Drs. Todd and Tohill into the use of the autobiographical medium not solely as a means of better understanding the sufferer's illness, but also as a means of therapy in of itself. The idea of autobiography writing as therapeutic is a central idea of this thesis to which further consideration will be given in the chapters which follow.

¹⁷ Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Australia and New Zealand, c. 1880-1910', *Social History of Medicine*, 19.3 (2006), 425-42; Jennifer Robertson, "'Unsettled, Excited and Quarrelsome": The Intersection of Violence, Families and Lunacy at the Auckland Asylum, 1890-1910' (MA thesis, University of Waikato, 2006); Emma C. Spooner, 'Digging For the Families of the Mad: Locating the Family in the Auckland Asylum Archives' (MA thesis, University of Waikato, 2006).

¹⁸ Rob Smith, 'The Muted Voice: Language as a Straightjacket in the New Zealand Mental Institution', *Journal of Sickness, Health and History*, Special Issue Interpreting Institutions: New Zealand Histories, 1930s-1960s, November (2002), pp. 107-15.

¹⁹ Alison Hunt, 'The Unhappy Present Recites the Past: Autobiography as Psychiatric Treatment in the 1930s Case of Robin Hyde', in *Telling Lives: Essays in Biography and History*, edited by Catharine Coleborne, Mark Houlahan, and Hugh Morrison (Hamilton: University of Waikato, Depts. of History and Humanities, 2006), pp. 105-29.

Two final areas of scholarship require brief mention. The first is a focus on political and social shifts in the perception and treatment of the mental ill. Waltraud Ernst's Chapter on 'The Social History of Pakeha Psychiatry', is important because of the way in which it has interrogated when and why New Zealand developed mental asylums developed.²⁰ The articles on deinstitutionalisation look mainly at what influenced the shift to community care and the effect of that shift on patients and service provision. Warwick Brunton's chapter 'Out of the Shadows' is also important because it briefly reviews New Zealand psychiatric history from a policy perspective, underling the key changes in policy and their implications.²¹ The second is the not inconsequential publication of specific institutional histories.²² The primarily look at the institution as a whole, and while the patient is included, as histories for a broadly public audience the do not often dwell on negative aspects of institutional care. They are however valuable for providing some idea of what institutional life was like prior to the move to community based treatment.

Despite the range of pathographies published in New Zealand, including narratives on various types of cancer, physical handicaps, and polio, this thesis focuses specifically on mental health pathographies. Those examined primarily discuss schizophrenia and depression and thus do not address an exhaustive list of the mental conditions characterized by the *DSM-IV*.²³ This narrow focus is directed chiefly by the availability of

²⁰ Waltraud Ernst, 'The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes, in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, edited by Linda Bryder (Wellington, Bridget Williams Books, 1991), pp. 65-84

²¹ Warwick Brunton, 'Out of the Shadows: Some Historical Underpinnings of Mental Health Policy', in *Past Judgement: Social Policy in New Zealand*, ed. by Bronwyn Dalley and Margaret Tennant (Dunedin, N.Z.: University of Otago Press, 2004), pp. 74-90

²² Anne Hunt, *The Lost Years: From Levin Farm Mental Deficiency Colony to Kimberley Centre* (Christchurch: A. Hunt, 2000); Adrienne Hault, 'Institutional Responses to Mental Deficiency in New Zealand, 1911-1935: Tokanui Mental Hospital' (MA thesis: Waikato University, 2007); Warwick A. Brunton, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997* (Hokitika, N.Z.: Seaview Hospital 125th Jubilee Committee, 1997); Bob Baird, *Lake Alice Hospital: 40 Years* (Wanganui, N.Z.: Community Health Services, Manawatu-Wanganui Area Health Board, 1990); Wendy Hunter Williams, *Out of Mind, Out of Sight: The Story of Porirua Hospital* (Porirua, N.Z.: The Hospital, 1987)

²³ The *DSM-IV*, divides the abundant number of identified disorders into 17 categories

relevant New Zealand pathographies, but is also constrained by the restrictions of the research, especially those of scale, which necessitated the selection of a limited number of narratives. Thus, existing New Zealand pathographies about dementia and anorexia have been excluded, a decision aided by popular conceptions of mental illness which more readily identify schizophrenia and depression as psychiatric disorders, the study of which has allowed me to engage with the popular mythology surrounding mental illness.²⁴

‘A clinically significant behavioural or psychological syndrome,²⁵ mental illness is an affliction of the mind ‘which causes serious abnormality in a person’s thinking or behaviour, especially one requiring special care or treatment’²⁶ and resulting in ‘an increased risk of suffering, death, pain disability, or an important loss of freedom’.²⁷ Furthermore, ‘this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one’.²⁸ This last point is important because it highlights the ‘framing’ process which Charles Rosenberg identifies as directing conceptions of disease.²⁹ Not simply a biological event, mental illness is framed by a variety of interconnected ‘social actors’, including religion,

ranging from ‘disorders usually first diagnosed in infancy, childhood, or adolescence’ to ‘personality disorders’ and ‘other conditions that may be a focus of clinical attention’. See contents pages of the *DSM-IV*.

²⁴ The existence of autobiographical and biographical works which discuss mental illness experiences, such as Janet Frame’s *Autobiography* (specifically Volume 2: *An Angel at My Table*, and Volume 3: *Envoy to the Mirror City*), and Denise L’Estrange Corbet’s *All That Glitters* (Auckland: Random House, 2008), are acknowledged. However, these works are not solely focused on the illness experience and therefore do not fit the definition of a pathography. Though not investigated as pathographies they will be used to provide context.

²⁵ Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR, prepared by the Task Force on DSM-IV and other committees and work groups of the American Psychiatric Association (Washington, DC: American Psychiatric Association, 2000), p. xxxi.

²⁶ John Simpson and others, eds, s.v. mental illness, Oxford English Dictionary Online <http://dictionary.oed.com.ezproxy.waikato.ac.nz/cgi/entry/00305962/00305962se24?single=1&query_type=word&qquerywor=mental+health&first=1&max_to_show=10&hilite=00305962se24> [accessed 12 June 2008]

²⁷ DSM-IV, p. xxxi.

²⁸ DSM-IV, p. xxxi.

²⁹ In his introduction to *Framing Disease* Charles Rosenberg posited the idea that disease is created by a biological event that is ‘framed’ by a range of social actors. See Charles E. Rosenberg, *Framing Disease: Studies in Cultural History*, edited by Charles E. Rosenberg and Janet Golden (New Brunswick, N.J.: Rutgers University Press, 1992).

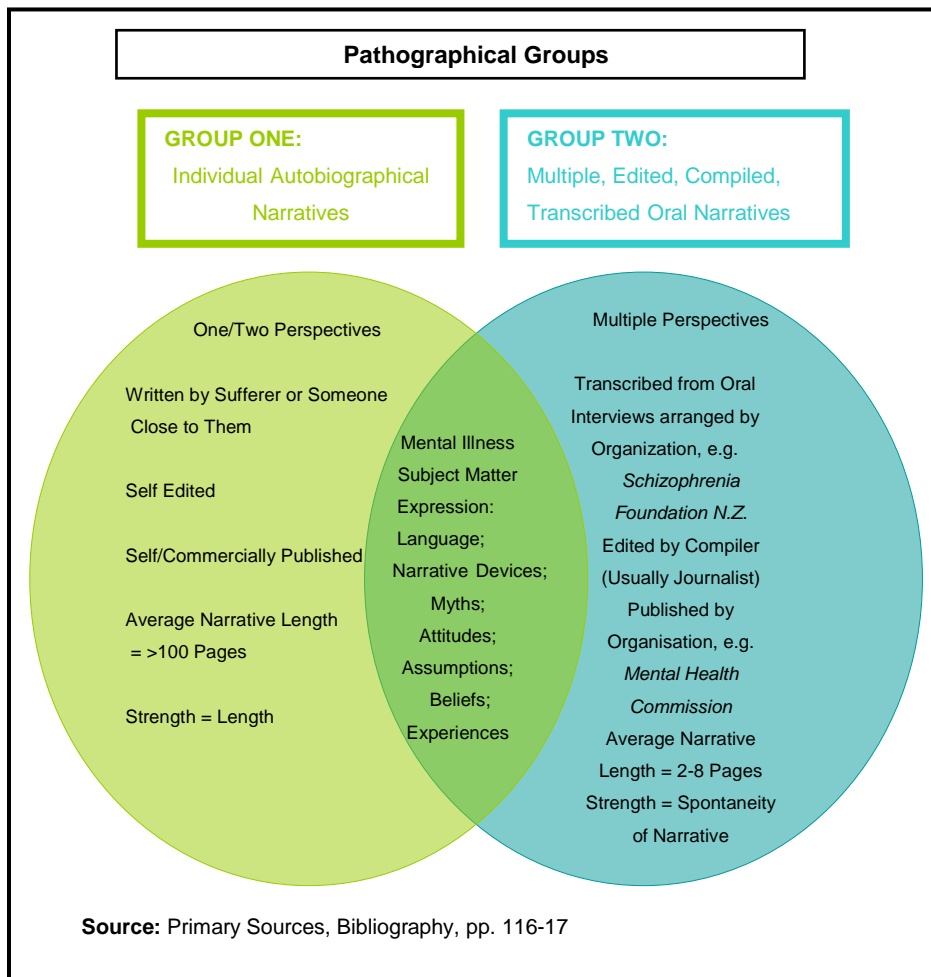
economics, law, medicine, politics and culture. An historical examination of the changing boundaries of mental illness makes evident this framing process. Over time, responses to, and conceptions of, abnormality undergo multiple transformations, a fact most visibly reflected in the changing nomenclature of mental illness.³⁰

I have divided the fourteen published narratives selected into two groups (see Figure 1). The first comprises individual, autobiographical narratives of mental illness, and the second consisting of multiple, collected, edited accounts which more closely align with Hawkins' broader definition. Despite differences of length, and production, the two groups, as the Diagram illustrates, overlap in subject matter and expression, including the attitudes and assumptions expressed, the myths and themes evoked, and the language and narrative devices used.

Of the differences which exist between the two groups, the most significant, for the discussions which follow, is the external nature of editing in the pathographies belonging to the second group. In particular this has relevance to the discussions of form which are the focus of Chapter One, because of the implication that pathographers have not had sole control over the direction of their narrative.

³⁰ Note: mental illness is a contest concept. A significant 'anti-psychiatric' literature has built up around the idea that mental illness is a coercive, stigmatising myth constructed and perpetuated by the psychiatric profession for self-serving reasons of professional advancement. Further, the myth is perpetuated and endorsed by society in general because it legitimates the controlling of 'problem' people, sanctioning their detainment and 'treatment'. Key theorists include Thomas Szasz, David G. Cooper, Ronald David Lang, Michel Foucault, Erving Goffman and Thoms Scheff.

Figure 1: Pathographical Groups



Significantly, the majority of the pathographies examined in this thesis are authored by New Zealand European sufferers between the ages of thirty and fifty. Although Māori, Pacific Island, and Asian perspectives were identifiable in the second group of collected narratives, significantly none of the pathographies of the second group were written by ethnic minorities. While definitively identifying the pathographers' socio-economic background was not possible numerous indicators, such as where they received treatment and the language they used, suggested that the majority belonged to the middle-class. Additionally, there is a prevalence of female pathographers, roughly double that of males when the collected narratives are taken into account.

Of the males who do write, two require introduction. Diagnosed with bipolar disorder Graham Bishop is in his mid-fifties when he is placed under compulsory in-patient treatment order and kept for a year at Wakari Hospital on the outskirts of Dunedin. A former geologist, Bishop's narrative is notable for its rational expression and its novel use of poetry to illustrate his deteriorating mental state. Of all the pathographies belonging to the first group, Bishop's is the most vocal in its criticism of the medical profession and his treatment. The second male pathographer is Ben Benjamin, who at the onset of his illness has taken over his family's retail business in Auckland. Over the course of seven years Benjamin endures a series of manic episodes all of which lead to him being hospitalised in five different institutions. His narrative provides great detail of what actually occurred and what was being thought at the time. However, his rationalisation of the events which occur does not detract from the disordered impact of the narrative. Of the pathographies examined, his account of manic depression is the most unsettling in its ability to draw you into experience.

Of the female pathographers, whose narratives are examined in this thesis, there are four which need further introduction. Suzanne Tocher's schizophrenia is shown to be the result of her traumatic military upbringing. In contrast to the largely silent role of her mother and siblings Tocher's father, as the instigator of this trauma, plays a central role. Tocher's use of paintings to tell her story is of greatest consequence, as these provide greater scope of expression, most notably through the use of colour to convey emotion. Similarly, Lorelei Burdett uses a range of media to narrate her account of bipolar disorder. In addition to paintings she includes diary excerpts, letters, newspaper articles and souvenirs from her stay in Hillmorton Hospital. The diary entries are especially interesting for the way in which they directly offer a window onto Burdett's confused thoughts at the time of her illness.

Kathryn Miller's narratives detail her unspecified illness, most notably in the third person. Reminiscent of Janet Frame, Miller's use of this perspective hints at the disassociated nature of her disorder. Seemingly

rejected by her mother and family Miller lives in an emotionally devoid landscape, retreating frequently into her own internal world, shunning reality. Detailing in *Kathryn* her search for answers to her problem Miller predominantly focuses on the unprofessional, detrimental treatment of 'the doctor'. In *Injustice* she thematically reviews what has occurred with her new psychiatrist 'Dr Jonathan', reflecting on why she is so fearful. Finally Suzanne Navart narrative is significant because it is one of the few which are written, not by the sufferer, but by a family member. Aligning with Hawkins' inclusion of narratives written by someone close to the sufferer, Navart narrates her daughter, Angelica's, illness, with Angelica's help. While living away from home in Sydney, Angelica has her drink spike by 'friends' which leads to her being raped. The trauma of this experience causes her to suffer a severe 'schizophrenic' breakdown. *Tears of an Angel* highlights the broader impact of mental illness, and also the ways in which silence due to incapacity may be overcome. Navart's narrative is interesting because of its figurative expression; there appears to be a desire to communicate the emotive consequences of illness, which looks beyond the specifics of occurrence.³¹

New Zealand's mental health history can roughly be divided into five key phases. The first, from the 1840s to the abolition of the provincial governments in 1876, is characterized by an optimistic outlook which favoured 'moral treatment' and 'non restraint'. In the late 1870s, coinciding with the government taking control of mental health provision, there arose a general feeling of therapeutic despair characteristic of the second phase. The 1940s and 50s saw therapeutic and pharmaceutical revolutions rekindle optimism with the promise of widespread cure; this third phase is one in which 'solutions' become achievable. Its developments are important to the fourth phase of deinstitutionalisation, which saw the rundown of psychiatric hospitals and the phasing out of

³¹ Following initial mentions of the pathographer's name I use, where know the surname of the pathographer for subsequent mentions. However, not all pathographers provide a surname and where only a first name is given I have necessarily had to use this. No disrespect for their authority as an author is intended. Additionally, where the perspectives of family members with the same surname are recalled, first names are used for clarity.

long stay institutional treatment in favour of community care. This centring of treatment in the 'community' is the foundation of the fifth, and current, phase of mental health provision. Beginning in the late 1990s, this phase is characterised by the impetus to normalise the treatment of patients through policies of mainstreaming and community care. The pathographies examined in this thesis were all written during the final two phases which have seen the reversal of confinement ideologies. In writing during these periods the authors are engaging with the various discourses which surround this very emotive shift in policy and practice. As they reflect on their institutional experiences, the pathographers consider the confinement ideologies which underpinned their treatment, but they do so with knowledge of current institutional philosophy, therefore allowing them to contrast their experiences and observations with current thought and practice.

This thesis begins its examination of the selected pathographies by examining the purpose, and form of the narratives. Chapter One initially considers the three central themes of institutionalisation, power and knowledge, and boundaries and identity. Given that many of the pathographers recount institutional experiences, it is unsurprising that the first of these themes features most prominently in pathographers' recollections. While ideas of power and knowledge, and boundaries and identity are evoked in relation to experiences *outside* the institution, their centrality to the theme of institutionalisation dominates.

This is followed by an examination of the structure of the pathographies. Firstly, the use of titles and forewords are considered, particularly the way pathographers legitimate their narratives by using sub-titles which conform to the conventions of non-fiction, and by including forewords by medical professionals whose authority and statement testify to the veracity of the experiences recounted. Secondly, I will examine the frames that pathographers use to shape their narratives, including battle mythology and narratives of loss, and the typically linear structure of most pathographies. The final section will discuss expression, particularly the narrative voice used, the language employed and, in

certain instances, the inclusion of alternative media such as poetry and art. The section considers the effects of these central features of expression in order to understand how meaning is conveyed in diverse ways.

Most of the pathographies are emotive in nature, although this is occasionally mixed with angry sentiments, particularly relating to treatment by the medical profession and the provision of services. Chapter Two investigates the way patients interact with the medical profession, their immediate relations and their wider social context (the relationships between them and their doctor/psychiatrist, other health practitioners, family, friends, associates and community). It considers what these interactions can tell us about the nature of the medical profession as it pertains to mental health care, and includes an examination of different sickness experiences, specifically between those who were institutionalized and those who received outpatient treatment, including the replacement support networks and communities which function, or perhaps do not function, for those who rely on community care.

As well as what the pathographies say, this thesis investigates what they do not. Luisa Passerini's focus on the 'un-said' in oral history has relevance for pathographical investigation.³² Chapter Three thus considers 'silences' in the narratives in order to understand what they indicate about individual experiences. This chapter will additionally examine those areas that appear to deliberately address issues that might otherwise be suppressed – the 'airing' of painful, embarrassing, sensitive truths, reflecting on how this is congruous with pathographical writing in general. In doing this, the chapter aims to reveal the more negative aspects of mental health history; those areas where patients feel they have been neglected or let down, where the communities meant to support them fail or are nonexistent – where they become victims of a system meant to aid them.

³² Luisa Passerini, 'Work Ideology and Consensus under Italian Fascism', *History Workshop Journal*, 8 (1979), 82-108

Collectively, the chapters consider the value of patient pathographies for investigations of mental illness. Their insights are especially valuable given the complex, chronic and variable nature of mental disorder. Broadly speaking, the thesis considers how pathographies tell, what they tell, and what they do not tell. In crafting therapeutic narratives of their experiences, New Zealand sufferers of mental illness express what it is like, physically, socially, and psychologically, to cope with mental affliction. Additionally, in writing their narratives, pathographers make sense of what has occurred and imbue that experience with meaning, and in so doing they communicate social and cultural understandings of illness.

Chapter One

Writing Madness: Form and Expression

In the act of conveying their narratives to paper, pathographers give shape to the contents by favouring one particular form of expression over the multitude of possible others, endowing their account with specific meaning. Anne Hunsaker Hawkins remarks:

It is important ... to remember that the narrative description of illness is both less and more than the actual experience: less, in that remembering and writing are selective processes – certain facts are dropped because they are forgotten or because they do not fit the author's narrative design; and more, in that the act of committing experience to narrative form inevitably confers upon it a particular sequence of events and endows it with a significance that was probably only latent in the original experience. Narrative form alters experience, giving it a definite shape, organizing events into a beginning, a middle, and an end, and adding drama – heightening feelings and seeing the individuals involved as characters in a therapeutic plot.³³

Hawkins' identification of pathography as a 'therapeutic plot' is significant because it highlights the restorative function of the genre. Indeed, by engaging in pathographical writing sufferers, whether they are conscious of it or not, heal themselves in ways that medical endeavour cannot. Most importantly, their writing symbolically restores their voice by providing a socially and culturally acceptable narrative form for their suffering, one which gains its authority from experience and overcomes the pitfalls of subjectivity by making it an asset.

This chapter examines the form and expression of the 'therapeutic plot', as embodied in New Zealand pathographies, in order to understand how the writing process shapes and alters the illness experience.³⁴ The

³³ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography* (West Lafayette, Ind.: Purdue University Press, 1999), pp. 14-15.

³⁴ The majority of the observations outlined in this chapter relate to pathographies from the first group (see introduction), these being most useful due to their conformity with

chapter is divided into three sections: themes, structure, and expression. The first section investigates the three principal themes of: institutionalisation; power and knowledge; and boundaries and identity. It reflects on their significance and their centrality to sufferers' conceptions and experiences of illness. The second section looks at several aspects of the structure of the pathographies, including titles, forewords, narrative structure, and narrative frames. It contemplates the importance of these aspects in guiding the direction of the narrative, and in shaping experience into a therapeutic account. The final section considers the specifics of expression, including narrative voice, multi media, and emotive, figurative and technical language. It investigates the way each of these elements influence meaning, shaping the expression of opinion and the articulation of experience. Overall, this chapter demonstrates the importance of the 'therapeutic plot' to sufferers' narratives. In offering pathographers a voice for their suffering which creates meaning and restores order and continuity it not only describes the recovery process, it is also part of it.

Themes

Pathographies exist because sufferers desire to communicate something, either to themselves or to a wider audience. Whilst initially they might be motivated by a personal need to make sense of the experiences they have undergone, publication suggests the existence or development of a broader purpose than self-explanation. They either wish to provoke change by informing others of their suffering, provide vicarious support for those similarly afflicted, or challenge conventional medical authority by suggesting alternative therapies. Thus, pathographers not only compose their narratives in accordance with the nature of their intended audience and with socially and culturally determined boundaries of acceptability, they also shape them to reflect their purpose in writing. This purpose finds its expression most readily in

conventional pathographical form. The second group of pathographies are less useful for discussions of structure because they have been externally edited, however, they are useful in evidence of mythic construction, specifics of expression and in thematic discussions, and have been utilised where relevant.

the theme, or themes, of the narrative – the overarching idea or message which the pathographer wishes to communicate. Although some pathographers choose to develop their own unique theme, the majority make use of prevalent and frequently universal discourses, a fact indicative of the central nature of certain aspects of the illness experience.

Three of the most significant, frequently evoked themes used by sufferers of mental disorder are discussed here. Though considered individually, it is apparent that ideas of institutionalisation; power and knowledge; and boundaries and identity are not mutually exclusive. Of the three themes appraised below, the most dominant is institutionalisation. In examining the various facets of this concept, pathographers invariably also discuss aspects of the other themes, these more fundamental ideas underpinning the other which is specific to conventional medical treatment. However, the most remarkable aspect of these themes is their negative evocation, the majority of pathographers using them to warn against the perceived pitfalls of the system of care under which they were treated.

All of the pathographies examined touch on the theme of institutionalisation, which is broadly perceived as an oppressive culture underpinning institutional care of sufferers of mental disorder. Most closely associated with long term treatment, the theme of institutionalisation is mainly evoked when discussing the manifestations and effects of this culture, and includes ideas of powerlessness, dependency, loss, abuse, force, fear, secrecy, imprisonment, and most significantly, control. For Graham Bishop, institutionalisation is summed up by what he terms ‘silly games’, where staff are deliberately obtuse, deceitful, and vindictive in their dealings with patients. Bishop describes an environment in which existence is governed by the subjective whim of individual staff who have absolute control and who appear to enjoy exercising it at the expense of patients, seemingly for their own amusement or, more disturbingly, simply because they can.

Many of the instances he recounts detail what are ostensibly trivial events, thus making their occurrence all the more unreasonable and inexplicable. Such instances include the denying of extra blankets on the pretext of insufficiency despite a room full of spares; the cancelling of leave at the last minute without sufficient explanation, or the deliberate delaying of leave and the invention of restrictions by an individual staff member in order to illustrate dominance; frequent searching of patients' rooms without permission or justification; and the fabrication of evidence in medical records, such as the confiscation of contraband items (an unopened bottle of wine).³⁵ Although these mind games may not appear to put patients in any direct physical danger, the psychological consequences are, at the very least, not conducive to recovery and, at worst, potentially fatal. As Bishop astutely notes: 'the challenge is not to create an environment where people cannot kill themselves, it is to create one where they don't want to'.³⁶

'Silly games' are not, however, the most alarming characteristic of institutionalisation. The controlling mindset that underpins them, though, is also the driving force behind more sinister and disturbing practices. Bishop evokes a picture of reckless disregard, endangerment and experimentation on patients without consent, informed or otherwise. He details personal instances of being medicated with unknown substances while asleep and being given medication disguised as cough syrup which carried a warning against use in patients with specific medical conditions; all of which were applicable in his case.³⁷ He also details, as do many other pathographers, instances where refusal to comply is countered with sedative medication, received either by force or under its threat.

The effect of this depersonalising, dehumanising, distorting, and militant institutional mindset on patients is to leave them feeling disempowered. Pathographers describe being made to wear common 'hospital' attire,

³⁵ See Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Steele Roberts, 2000), pp. 84; 85; 103; 86-7; 86, respectively.

³⁶ Bishop, p. 84.

³⁷ Bishop, see pp. 106-7; 91-2, respectively.

being herded like livestock, having to shower collectively and perform basic hygiene practices without privacy.³⁸ All of these measures dispossess patients of their sense of self; they have nothing with which to distinguish themselves from the collective. So conditioned, patients are robbed of their individuality, their dignity, their agency and their humanity – they become institutionalised. Ben Benjamin likens this state to ‘treading water’; where existence has no greater purpose than survival and where one’s vision is confined, physically and psychologically, to a limited institutional landscape.³⁹ He provides a striking illustration of this state when detailing the motivation a fellow patient supplies for reclaiming life beyond the hospital walls:

He had been there for seventeen years and looked destined to spend the rest of his life in the place. I took one look at him and realised that unless I made a break and tried to make a go of it in the outside world, I too would be condemned to being stuck in institutions for the rest of my life... I had come to the momentous conclusion that I would rather die living than live dying.⁴⁰

This image of living death is an extremely powerful one. In it, Benjamin not only highlights the plight of sufferers who become institutional fixtures and succinctly captures the atmosphere that allows them to become so, he also conveys the fear that he and many other sufferers’ have of becoming just such a fixture.

Fear of becoming institutionalised motivates patients to secure their release, and to do so many, including Suzanne Tocher and Kathryn Miller, mask the true state of their illness by performing a role of controlled normalcy.⁴¹ However, in performing recoveries, patients mirror the deceptive behaviour of staff, becoming complicit in the

³⁸ See Ben Benjamin and Ian Dougherty, *Out of My Mind: Living with Manic Depression* (Auckland: Tandem Press, 1994), p. 32; *Shadows and Silence*, narratives gathered, edited and compiled by Clare Goodwin (Wellington: Steele Roberts, 2004), p. 16; and *A Gift of Stories*, gathered, edited and compiled by Julie Leibrich (Dunedin: Otago University Press, 1999), p. 35. Anne, a psychologist at Kingseat Hospital, 1961-2, also notes the use of ‘universal clothing’. See *Shadows and Silence*, p. 22.

³⁹ See Benjamin, p. 105.

⁴⁰ Benjamin, p. 105.

⁴¹ See Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington: Philip Garside, 2001), p.37, and Kathryn Miller, *Kathryn* (Rotorua: Tancred Press, 1984), pp. 170-71.

underlying culture of secrecy which dominates interaction. A side effect of institutional care, this deception is most significant in that it cultivates staff/patient distinctions and encourages antagonistic relations, neither of which aid recovery, and both of which highlight the underlying struggle for power that attends institutional ideologies.

In discussing institutionalisation pathographers inevitably also discuss ideas of power and knowledge, the three being interconnected. Power lies at the heart of the culture of dependency and dominance which characterises institutional practice, even being reflected in the physical site deemed appropriate for treatment. Isolated and fortified, many pathographers liken psychiatric hospitals to prisons; with locks and keys the dominant imagery evoked in recollections.⁴² In particular they highlight seclusion as a key aspect of this imprisonment ethos. It is a practice, they argue, that has nothing to do with the mental state of the sufferer. 'Instead', Graham Bishop asserts, 'it was about power, it was to bring home to me that I was now totally powerless. The nurses were power and I would toe the line or I would be back in here for as long as it took'.⁴³ Not only are patients unable to move about as they choose (one pathographer even describes having to go through 'three locked doors' just to 'get to the toilet'⁴⁴), being reliant on the subjective disposition of staff as to when and where they can go, the system also purposely makes them aware that their movements are easily observed and thus monitored; the knowledge of which is intended to promote conformity and quash individuality. Patients are thus disempowered on two fronts; they are deprived of freedom of movement, making them subject to the authority of staff, and their movements are placed under a microscope conveying to them that they are being watched and have no privacy.

The surveillance of patients is also significant in that the observations become part of the official record of the illness experience, and are another way in which staff can exercise control over patients. The casenotes kept about patients are significant for two reasons; they have

⁴² See *Shadows and Silence*, p. 16; *A Gift of Stories*, p. 35 and Bishop, p. 83.

⁴³ Bishop, p. 83.

⁴⁴ *Shadows and Silence*, p. 16.

authority beyond institutional walls and dominate official narratives of mental health, and they are popularly perceived to be objective, and therefore their contents are given great weight legally and socially. This dominance of wider public opinion not only puts patient perspectives at a disadvantage, it also affords staff greater power as the implicit veracity of their claims allows them greater freedom from proof. This power is further strengthened by the secrecy which surrounds the records. Patients do not have access to what is being written while in the institution, often only acquiring the knowledge at a later date. As such, the fear of what might be written is a key threat because of the weight attached to the information. However, Suzanne Tocher and other pathographers astutely point out the subjectivity and prejudice of these notes, and the inaccuracy of their claims to factuality.⁴⁵ In so doing they are challenging their textual authority.

Not only do institutions control information, they also manufacture it; a fact of great significance when considering the power it exerts over patients through the control of public opinion. The labelling of patients is a key aspect of this, especially if one subscribes to the belief that such diagnoses are prescriptive rather than descriptive. In being labelled, patients are being 'othered' – distinguished negatively from the rest of humanity. The exact diagnosis given is significant because certain terminology is more sympathetic than others. 'Breakdown' is more euphemistic than psychotic episode, and a 'schizophrenic' person is more negative than a person with schizophrenia as it conflates patient and illness. Fear of such labels and their social consequences is a powerful means of control, especially when patients are not privy to what is being written about them.

Additionally, the institution is itself a site of 'othering'. Time spent in a psychiatric hospital tarnishes patients with the stigma attached to mental illness. Crossing the threshold of the institution is to cross the border between reason and insanity. Immediately words carry less weight; the accuracy of their claims are automatically questioned. Patients'

⁴⁵ See Tocher, pp. 35-7.

awareness of this fact is intentional. They are psychologically conditioned to understand that their complaints and criticisms have little weight and as such are at an extreme disadvantage. Furthermore, the pervasive punitive atmosphere sees mental illness linked with criminal behaviour and thus similarly treated and condemned.⁴⁶ Patients understand that their status as 'insane' renders them largely powerless.

Why this power imbalance exists and is enforced by staff is of vital significance. Two related reasons present themselves to explain why the oppression of patient autonomy is an integral aspect of mental health care. Most practically, this can be seen to be the result of a numerical imbalance – patients outnumber staff and in order to maintain control, staff must have absolute authority. However, as Graham Bishop and others have illustrated, the exertion of power frequently has nothing to do with patient behaviour. Instead it appears to be deliberately vindictive. Thus, staff's maintenance of control is about more than physical control: it is about control over sanity and reason. Institutions are places where sanity and reason become skewed; sanity being outnumbered by 'madness'. Therefore maintaining power is about maintaining sanity and the fear of losing control. Sanity drives staff to militantly quash any exertion of rival authority.

In discussing the themes of institutionalisation and power and knowledge pathographers also discuss the concepts of boundaries and identity. Ideas of illness and boundaries are fundamentally connected, for illness unavoidably involves crossing the boundary that demarcates sickness from health. For sufferers of mental disorder boundaries are especially significant as the chronic nature of affliction leaves them inhabiting a border region characterized by a state of tenuous wellness that is underpinned by the perpetual fear of relapse. Unsurprisingly, the institution is a key site of distinction where boundaries are enforced, created and distorted. Most obviously, institutions are physical

⁴⁶ Natasha highlights this criminal association when she states 'You were doing time, that's what it felt like. The first night I was there, I thought I must have committed a murder the night I was drunk. It was the only reason I could think of for being there' See *Shadows and Silence*, p. 16.

boundaries separating the 'abnormal' and 'unsafe' from the 'normal' and 'vulnerable'. Being institutionalised literally involves crossing a threshold, be this a gate or doorway, which separates the external ordered world from the confined internal disorder of the 'mad'.

Patients express awareness of this boundary, and its custodial function, in their descriptions of institutional layout. For Graham Bishop the enormous 'dungeon like' keys of Wakari Hospital serve as a reminder that he has crossed the boundary which separates outer freedom from inner control. He notes: 'I was never sure of the psychology behind them. I presumed it was a deliberate attempt to emphasise they you were being shut away from the rest of the world'.⁴⁷ This comment highlights the fact that crossing the physical boundary of the institution equally involves crossing social and psychological boundaries.

Time spent in an institution carries with it the taint of abnormality and social rejection; sufferers have crossed a boundary of acceptability which is enforced by social prejudice and stigma. Furthermore, their awareness of this boundary is a central aspect of its operation. In describing her daughter's admission to Kingseat Hospital, Suzanne Navart notes: 'I understood my daughter was frightened in the hospital. This was partly due to the illness and partly because she was vaguely aware she was in a hospital for people with a mental problem'.⁴⁸ Similar sentiments are expressed by Tania who states: 'When I first went into hospital I went in with all my own in-built prejudices against people with mental illness. So that was magnified, "Shit I've become like that!"'.⁴⁹ Social boundaries are especially important because of their centrality to existence, and as Navart and Tania illustrate, their absorption by the sufferer makes it doubly hard to be afflicted.

Additionally, this 'otherness' is reinforced once inside the institution where patients are made aware of their difference by being labelled as

⁴⁷ Bishop, p. 83.

⁴⁸ Suzanne Navart, *Tears of an Angel*, (Auckland: Suzanne Travan, 2000), p. 88.

⁴⁹ Mental Health Commission Recovery Series, *Four Māori Korero about their Experience of Mental Illness* (Wellington: Mental Health Commission, 2000), p. 13.

patients. This not only identifies their difference with their illness, it also highlights the socially and ideologically barrier which demarcates patients from staff. Ben Benjamin notes that the staff at Rozelle public hospital 'were friendly but detached', highlighting the determination of staff to maintain these boundaries.⁵⁰ While patients' experiences of this 'othering' process are often crystallised in the institution it is important to recognise that it occurs regardless of whether a patient has been committed. These aspects are predominantly psychological, reflecting patient's perceptions of their illness. In addition to crossing the boundary between sickness and health they also cross they boundary between normal and abnormal, and good and bad. Frequently this is expressed through the use of light and dark. This is congruous with social perceptions of illness which view illness negatively as a dark phase in a person's life or leading to the total darkness which is death. This last association is also important because it highlights the boundary between life and death. This boundary is highlighted by numerous sufferers' accounts of suicide attempts.⁵¹

In crossing these boundaries sufferers encounter consequences, most significantly the personal and social ramifications of the destabilising effect which illness has on identity. This is especially relevant for sufferers of mental disorder where illness is intricately linked with personality and identity. Crossing the boundary between sickness and health also fundamentally challenges the sufferers' identity as they come to inhabit another space and role – they are an ill person, or in the case of mental illness they are a 'disordered person'. This new identity is reinforced, as noted above, through labelling, sufferers are 'patients' and they are specifically labelled with a disorder, whether this is schizophrenia, bipolar, or depression. Natasha directly links this labelling process and the recording of casenotes with judgement of self and identity:

As soon as I was put in there I was labelled as having a mental illness. Whatever I did or said was part of that mental

⁵⁰ Benjamin, p. 32.

⁵¹ See Bishop, p. 86; Tocher, p. 24. *A Gift of Stories*, p. 28.

illness. If I was having a quiet day, they would say I was not social.⁵²

Natasha's comment illustrates how a diagnosis can become an identity, which encompasses all behaviour and characterizes it as being abnormal.

Regardless of whether sufferers are institutionalised or not this process of questioning identity occurs. However, as noted above, the institution is a key site where identity is created and preformed, especially the role of patient which is subordinate to that of staff. Medication has a central role in the medical shaping of identity as sufferers' connection with the surroundings is frequently blurred. Many sufferers recount the negative effect of medication on their ability to engage with their surroundings, especially Alex, who in answer to his psychiatrists question about what the worst thing was about his illness offers the following response: 'I remember gazing out the window with blank eyes and saying that I didn't know who I was anymore'.⁵³ Alex's comment highlights the fact that not only mental illness, but also its treatment can destabilise identity.

Writing pathographies is a key way in which sufferers come to terms with their new identity. The therapeutic plot characteristic of illness narratives requires sufferers to make sense of their experiences and present situation by creating a coherent narrative which connects the illness experiences with what has gone before. In so doing pathographers distinguish their self as the person who these things have happened to reconciling their 'self-in illness' with their 'self-in-life'.⁵⁴

Structure

The most conspicuous aspect of form in any written account, and the most consequential in determining readership, is the title. Conventionally

⁵² *Shadows and Silence*, p. 16.

⁵³ *Mums and Dads*, p. 6.

⁵⁴ Hawkins, p. xviii.

this informs the reader of the subject and nature of the narrative to follow, while also expressing its uniqueness, ideally piquing the reader's interest. The titles of the pathographies under investigation fall roughly into two categories, those which directly address their illness subject, and those with a more ambiguous, personal focus. The former includes Suzanne Tocher's *Well Connected: Journey to Mental Health*, Ben Benjamin's *'Out of My Mind': Living with Manic Depression*, and Graham Bishop's *Poles Apart: A Touch of Madness*.⁵⁵ All three openly introduce their mental illness topic, respectively using 'mental health', 'manic depression', and 'madness' in their titles. Additionally, Tocher evokes biological explanations of mental illness by using the verb 'connected' which recalls theories of chemical imbalance and neurological function. Benjamin references popular perceptions of mental illness by suggesting that manic depression is akin to being out of one's mind, and also highlights the chronic nature of mental illness by using the verb 'living'. Bishop wittily emphasises the psychological extremes characteristic of bi-polar disorder by using 'poles apart' to simultaneously evoke the mental poles of mania and depression and the geographical North and South polar regions, thus analogously comparing the respective distances between. Furthermore, Bishop and Tocher's titles each reflect the overall tone of their narratives. Tocher's reference to 'mental health' as opposed to illness mirrors her overall positive attitude, and Bishop's 'A Touch of Madness' indicates the ironic lens through which his narrative is recounted.

The titles belonging to the second category include *Kathryn* and *Injustice*, both by Kathryn Miller, Suzanne Navart's *Tears of an Angel*, and Lorelei Burdett's *Mummy Why Did You Lie in the Middle of the Road?*⁵⁶ In contrast to the pathographies in the first category Miller and Navart's titles are remarkable because they do not directly address their

⁵⁵ Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington, N.Z.: Philip Garside, 2001); Ben Benjamin and Ian Dougherty, *'Out of My Mind': Living with Manic Depression* (Auckland, N.Z.: Tandem Press, 1994); Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington, N.Z.: Steele Roberts, 2000)

⁵⁶ Kathryn Miller, *Kathryn* (Rotorua, N.Z.: Tancred Press, 1984) and *Injustice* (Rotorua, N.Z.: Tancred Press, 1987); Suzanne Navart, *Tears of an Angel* (Auckland, N.Z.: Suzanne Travan, 2000) Lorelei Burdett, *Mummy Why Did You Lie in the Middle of the Road?* (Christchurch, N.Z.: L. Burdett, 2008)

mental illness subject. To a lesser extent this also applies to Burdett's title, for although she does not overtly specify mental disorder the title is most indicative of this. Instead of informing about the physical manifestations of mental illness, as is central to the first category, these titles touch on the personal and wider social costs of affliction. *Injustice* and *Kathryn* draw attention to the personal cost of mental illness, the latter, being named after the author, and exemplifying the narrative's preoccupation with identity, and the former referencing the lack of recourse patients have for harmful treatment – their illness status discrediting their claims of negligence. Using 'tears' in her title, Navart conveys the anguish, sorrow and suffering which attends her daughter's traumatic illness, and her use of 'angel' portrays that sufferer, via direct comparison, as being innocent. Burdett's title, oriented from a child's perspective, highlights the impact of mental illness on families. She uses an actual question posed by her children following a particularly distressing incident. Burdett comments, regarding her title page, that she 'needed to convey through the title and image how a child might react on seeing their mother lying, apparently intact but in stunned distress, on a suburban street'.⁵⁷ In so doing, Burdett draws attention to the plight of families who share in the sufferer's affliction, and therein to the multiple victims of mental illness. While the titles in the first category clearly indicate their non-fiction perspective, most evidently by elucidating their subject with a subtitle, the titles belonging to the second category are equally, if not more, suggestive of fiction. Whilst this style allows greater freedom of expression, less confined by convention, the ambiguity of subject and orientation detracts from the narrative's authority. Its form does not openly indicate non-fiction, being more reminiscent of fiction, thus its claims to truth tend to be diminished.

Following the title, the foreword is the next significant feature of the pathographies.⁵⁸ Ben Benjamin, Suzanne Tocher, Brian Hair and Lorelei

⁵⁷ Burdett, front page

⁵⁸ Note that, whilst some pathographies use preface instead of foreword, for the purposes of clarity I have chosen to solely use foreword to describe of the introductory segment, by a member of the medical profession, which precedes the main narrative. Nevertheless, this term is intended to be read as inclusive of those prefaces which conform with the above criteria.

Burdett all include an opening segment by their psychologist, doctor, counsellor, or occupational therapist, and Suzanne Navart's narrative features similar testimonies on the back cover.⁵⁹ In no more than three pages the foreword briefly introduces the struggles faced by the pathographer and praises their courage not just in confronting those struggles but also in writing about them. Primarily the forewords testify to the veracity of the sufferer's narrative, lending authority to the account. While the inclusion of professional medical testimony is not confined to pathographies with a mental illness focus, its addition is of great consequence given the destabilising nature of mental disorder. The lucidity and skill with which the narratives are told challenge popular perceptions of sufferers as uncomprehending, incomprehensible lunatics. Indeed, the subject matter of the narratives (frequently inclusive of bizarre occurrences) is seemingly incongruous with its articulation, prompting the reader to question the truthfulness of the suffering recounted. The foreword functions as a reassurance to the reader that the account is in fact genuine, and as such appears to be an important aspect of pathographical form.

Given their influence, it is interesting to note the exclusion of forewords from both Kathryn Miller and Graham Bishop's pathographies. One explanation for this absence lies in pathographical convention. Those narratives with forewords have all been published after 1990, the majority post 2000. This trend reflects the changing nature of pathographical form in response to broader shifts in medical relationships; most significantly towards partnerships of care which promote joint authority in recovery. Miller's narratives, published in 1983 and 1987, belong to the period prior to this shift; before the inclusion of a foreword became more common. While this explanation seems most plausible in Miller's instance, its applicability to Graham Bishop's narrative, published in 2000, is markedly less. Given his pathography falls within the foreword period, deliberate exclusion seems a more accurate reason for the absence. With an additional three publications to

⁵⁹ See Benjamin, p. 7; Tocher, p. 7; Hair, p. 6; Burdett, pp. 13-14, and Navart, Back Cover.

his name, and thus something of an established reputation; Bishop may feel a foreword is unnecessary to affirm his authenticity and accuracy. However, his narrative also makes clear his negative experience with the psychiatric profession, providing the most likely explanation for the exclusion.⁶⁰ Given his expression of hostility towards disempowering, inhumane care by psychiatrists and other mental health professionals it is unsurprising that he does not value their opinions, nor give credence to them by using them to validate his own account.

Moving beyond the framing elements of title and foreword it is important to discuss narrative structure because it reveals how pathographers shape their experiences into a therapeutic plot. The majority of the pathographers narrate their accounts using a linear arrangement, which recounts key details and events in order of occurrence. While in many instances this is a reflection of the pathographer's limited narrative skill – most being of novice ability and thus largely restricted to a straightforward linear narrative – it is also indicative of the therapeutic function of pathography, which provides sufferers with a legitimate form for their narratives and affords them the opportunity to rationalise their experiences. In writing their accounts pathographers are required to bring order and reason to bear on their suffering. In so doing they fulfil a more personal need to make sense of, and gain control over, the events that have occurred; not just to describe the 'disordering process', but also, as Anne Hunsaker Hawkins notes, 'to restore to reality its lost coherence and to discover, or create, a meaning that can bind it together again'.⁶¹

Most pathographers begin their narrative by selectively outlining their child or pre-adulthood, thereby providing a frame for the main illness events described and most importantly affirming their identity.

Chronologically situating the illness account within their wider life

⁶⁰ Kathryn also recounts a negative psychiatric experience, but unlike Graham she manages to establish a positive and beneficial relationship with another psychiatrist (Dr. Jonathan), and uses the 'memories of the therapy received' from him as the basis of her second pathography *Injustice*. Her exclusion of a foreword seems more likely to be the result of pathographical convention.

⁶¹ Hawkins, pp. 2-3.

narrative allows the pathographer, Robert Jay Lifton asserts, to recreate the connections between the ill self and existence prior to affliction.⁶²

The strengths of a linear sequence are twofold. Not only do pathographers produce an account that, in theory, is most comprehensible, in so doing they also garner greater credibility due to the weight society places on logic; a fact most important given the irrational nature of the subject matter. Furthermore, in rationalising their experiences they therapeutically construct a narrative of self and suffering. However, mental illness rarely makes sense, nor conforms to any particular order, thus a sequential structure can frequently seem contrived. It may inform about the specific occurrence of events but fail to allow scope for explanation of why they occurred, as frequently this requires evocation of past experiences.

Alternatively, pathographers can use a thematic structure, focusing on central ideas such as mental illness, identity, psycho-analysis, love, reality, fear, death, and guilt, to list a few which appear in Kathryn Miller's *Injustice*. The focus of this approach is on explanation, and its main strength is the scope it allows for expansion of reasoning and the connection of chronologically distant events; pathographers are able to reflect on the meaning of events without having to provide an accurate sequence of occurrence. However, many of the ideas which underpin narratives of mental illness are interconnected, thus drawing boundaries between information to create distinct ideas is somewhat artificial and invariably leads to repetition. Conversely, this need not, entirely, be a disadvantage as it also provides valuable insight into the perceptions of sufferers, providing information about how they rationalise and connect their thoughts. Nevertheless, focusing on multiple ideas can leave the main argument of the pathography unclear, thus reducing its impact. Moreover, the thematic approach tends to distort the narrative's sense of occurrence, making it difficult to gauge the extent of the period during which the events described occurred and moreover complicating recognition of the sequence of events. Whilst this might allow more for

⁶² Robert Jay Lifton, *Death in Life: Survivors of Hiroshima* (London: Weidenfeld & Nicolson, 1968). See also Judith Lewis Herman, *Trauma and Recovery* (London: Pandora, 1994)

accurate reflection on the experience of mental affliction, it obscures the connecting logic of the narrative, casting doubt over its reliability.

Guiding the structure of the narrative is the frame which pathographers use to organise their experiences. This frame, whether archetypal or unique, is important not only because it reveals how sufferers think about, characterize and comprehend their experiences of infirmity, but also because in doing so it reflects social and cultural beliefs about illness. Making sense of the events that have occurred and therapeutically imbuing them with meaning is a central function of the narrative frame. To do this, Hawkins notes, many pathographers engage in mythic thinking.⁶³ 'Mythologization', Kali Tal asserts, is a coping strategy which 'works by reducing a traumatic event to a set of standardized set of narratives ... turning the frightening and uncontrollable event into a contained and predictable narrative'.⁶⁴

Narratives of battle are, unsurprisingly, the most commonly evoked mythic frames used by sufferers in the pathographers which are examined in this thesis. Many view their illness as either a personal struggle against their own mind or more externally as a battle with the medical profession to get adequate treatment. Battle ideology is central to Graham Bishop's narrative which details the experiences which he endures in Wakari Hospital as a series of confrontation with staff. He notes: 'Life dragged on at 9B – always the noise, the agro, and the skirmishes with certain staff'.⁶⁵ Of the numerous instances which he details, one in particular is useful for illustrating the battle myth. The excerpt which follows details an incident where his room is searched for contraband items:

a trio of heavies burst in and roared round the room like a cartload of demented monkeys – on the first pass actually missing the bottle which was open in full view. It was, I suppose, a rather stupid thing to do, and I cheerfully

⁶³ Hawkins, pp. 18-23.

⁶⁴ Kali Tal, *Worlds of Hurt: Reading the Literatures of Trauma* (Cambridge: Cambridge University Press, 1996), p. 6.

⁶⁵ Bishop, p. 85.

accepted afterwards when they searched my bags or pockets as I came in – but there was never anything to be found – I wasn't going to be that stupid twice. However it didn't deter my *bête noire* from recording in my file that several months later he had confiscated an unopened bottle of wine from my room. I was surprised he didn't fabricate a corkscrew too.⁶⁶

The use of the words 'heavies', 'roared', 'demented monkeys', and 'bête noire' all convey a sense of antagonism and are noticeably confrontational. 'Bête noire' in particular highlights Bishop's hostile relationship with that particular staff member and hints at an ongoing conflict. Furthermore the use of sarcasm in the last line is Bishop's deliberately subversive way of fighting back.

Significantly, Bishop's pathography is also a narrative of loss, suggesting that although he won the war and secured his freedom, this was done at great cost. He notes: 'The failure of the little tin gods of Hypocrites (psychiatrists) to listen to those that knew me has probably cost me many unnecessary weeks or even months in hospital'.⁶⁷ Bishop is not alone in recounting loss. Many pathographers are keenly aware of what their mental illness has cost them, whether it is a loss of friends, health, faith, assets, or time. Ben Benjamin is even able to put a cost on the damage his manic state caused: 'In my wake was about \$10,000 dollars worth of damage to the house and contents'.⁶⁸ In identifying loss as a key narrative frame, Kerry Davies highlights the way it 'acts both as a way of expressing a particular experience and as a means of structuring whole narratives. There are elements of loss within the narratives of all participants ... but, for some, loss significantly structures and symbolizes their whole experience'.⁶⁹ Angelica's narrative is primarily a narrative of loss:

Sometimes, back in those four years I was unable to discern between night and day. There was merely a continuum and

⁶⁶ Bishop, p. 86.

⁶⁷ Bishop, p. 42.

⁶⁸ Benjamin, p. 54.

⁶⁹ Kerry Davies, "'Silent and Censured Travellers'? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948", *Social History of Medicine*, 14.2 (2001), p. 276.

time silently ticked across every second and I was unaware of time passing because I was captured within the shadows of my mind. ...

Today, I think about my loss and wonder if one day the edge of this past pain and the memory will change and I will no longer need to feel it.⁷⁰

Angelica's narrative centres on her lost self and perspective. Loosing her grasp on reality she moves into a shadow world where she fails to notice her external context. In writing this narrative of loss Angelica emphasises her perception of the overwhelming trauma and loss caused by her mental illness and the personal and social ramifications of this. Meaning is not just conveyed through the structure of the narrative, it is also shaped by the expression which the pathographer uses.

Expression

The most immediately obvious aspect of expression is narrative voice; the use of a first, or third person perspective. Given the author is most commonly the subject of the account, it is unsurprising that most of the pathographers use a first person viewpoint to articulate their narrative. In conforming to autobiographical convention, the use of the first person affords pathographers a greater connection with their audience, allowing for the possibility of establishing a rapport and winning trust. It is also more likely to reinforce the veracity of the pathographer's claims as experience is its own authority and a first-hand account is perceived as being more accurate than second-hand information. Narrative voice is also used to control the degree of attachment which the reader feels to the subject, and thus a first person perspective usually makes the reader feel more involved in the story and more compassionate towards the narrator.

However, the closeness to the events described that is denoted by the first person perspective, may also suggest compromised objectivity. To overcome this problem the pathographer may use a third person

⁷⁰ Navart, pp. 1-2

perspective in an effort to create a feeling of greater objectivity and hence accuracy. This may explain why Kathryn Miller, in both her pathographies (*Kathryn* and *Injustice*), uses third person narration. While the use of 'Kathryn' as opposed to 'I' suggests superior insight, it also can distort and weaken the strengths of pathography as a personal account of affliction. In reading more like a work of fiction, the use of the third person challenges the readers' belief in the reality and veracity of the narrative as a non-fiction account. An alternative, more likely explanation suggested by the narrative for Miller's use of the third person, is that it aligns with her self-perception. Reminiscent of Janet Frame, Miller sees herself as a 'non-person', disassociating self from identity.⁷¹ She narrates her life as an observer because she does not feel connected to the events described. In so doing, she also hints at the underlying cause of her mental illness.

As well as narrative voice, pathographers use a variety of emotive, figurative and technical language to express their experiences. The pathographies were notable for their use of moral and emotive language, suggestive of strong feelings, including anger, pain, fear, frustration, and despair. Words such as 'good' and 'bad', and variations of this theme such as 'wonderful', 'great', 'horrendous', and 'terrible' are not unexpectedly common in most of the narratives; however, it was the narratives in *Shadows and Silence* which exhibited the most usage, presumably because they specifically recount institutional experiences, which in and of themselves are a highly emotive subject. Jane, for example, describes the main sister as 'awful', and when made to discipline a patient by taking her upstairs, removing all her clothes, and leaving her in her room she describes the event as 'terrible'. She goes on to use adjectives such as 'really dreadful', 'very violent', 'quite wrong', and 'very demented'.⁷² Jane's use of moral and emotive language gives force to her narrative and conveys her standpoint regarding the events she describes.

⁷¹ Describing the legacy of her hospital treatment Janet frame states 'I arrived home at Willowglen, outwardly smiling and calm, but inwardly with all confidence gone, with the conviction at last that I was officially a non-person'. See Janet Frame, *An Autobiography* (Auckland: Random Century, 1991), p. 224.

⁷² Goodwin, p. 15.

Additionally, we need to consider Jane's motivation for using this language. Does she express such emotive opinions because she truly feels the event to be 'terrible' or because she is expressing the 'appropriate' response as dictated by society? Given the subject matter the latter is a possibility; mental hospitals and mental illness in general elicit strong responses from the wider public. If we also consider the performance-based nature of the orally generated narratives the argument of social influence gains more weight. While the emotive language used by sufferers may, in part, be a performance of wider social understandings, it would be a mistake to consider their narratives as entirely socially structured, especially when many of them express positive as well as negative sentiments. The presence of emotive and language in narratives is important because it affords an economy to the narrator, in which they are able to convey to the audience the not only the effect on them of the events described, but the force of that effect.

In addition to emotive language, pathographers frequently use figurative language to express experience. Poetic devices are a highly effective means of communication because they enlist comparison to aid explanation and they hold or grasp the readers' attention more effectively. They are thus a significant element of form for the power they can exert over the readers comprehension. Such usage can be revealing of individual truth and perceptions regardless of the factuality of the events described. The narrative power of these and similar devices is significant as the narrator attempts to convey meaning using concrete and abstract images and comparisons.

In *Shadows and Silence* most of the imagery is used to convey negative experiences in which the sufferer feels powerless, controlled, and sub-human. For example Natasha's narrative is quite striking for the way it links patients with livestock. She describes being 'herded into the bathroom naked' and also 'herded into the room like sheep'.⁷³ The use of the word 'herded' and the comparison to sheep are powerful images:

⁷³ Goodwin, p. 16.

being 'herded', in its link to cattle, connotes sub-human treatment in which patients lose their individual identity and become part of a collective, and the comparison to sheep implies the innocence and powerlessness of the patients, and perhaps refers to the use of sedatives to make them docile and easily controlled. The above example also touches on another key image of many of the narratives, and that is nakedness. The use of nakedness as punishment is very symbolic as it once again suggests sub-human treatment; humans can be distinguished from animals, in part, by the clothes they wear, to remove them leaves one unclothed as animals are.

Alex's story in *Mums and Dads* is also worth examining further. He describes 'taking a cocktail of medications' and being 'in a total fog'.⁷⁴ These metaphors are not original, no doubt drawn from similar descriptions he has heard used by others. This, however, does not render them ineffective. In describing the mixture of high dose medication he was on, the comparison to a cocktail conveys the idea of excess, that of multiple ingredients (drugs) and the dangerous possibilities this combination entails (alcohol's ability to alter the mind). Alex is expressing the irresponsibility of his psychiatrist and also explaining why he felt 'completely stupefied'; the 'total fog' he was in.⁷⁵ Indeed his description of this state as being fog-like conveys a sense of being isolated – unable to connect with the landscape around because it has become obscured by an impenetrable substance – the drugs have the effect of fog, and Alex's apt comparison conveys his state of being.

The use of imagery in these pathographies is often very emotive in itself. Alex's 'blank eyes' evoke a vision of someone who is detached from the world, who cannot see, and whose soul has been broken.⁷⁶ In reading this we cannot but have sympathy for his plight. The use of such imagery, and others not directly discussed here, is important because of the power it has to convey meaning. Our foremost sense is our sight, which provides us with knowledge via images. In invoking images that

⁷⁴ *Mums and Dads*, p. 6.

⁷⁵ *Mums and Dads*, p. 6.

⁷⁶ *Mums and Dads*, p. 6.

the reader is likely to already know the narrator is able to effectively communicate an experience which given subjectivity they could not experience themselves.

Another example is Graham Bishop metaphorical representation of psychiatrists as 'rabbits'. Bishop does not directly explain why psychiatrists are rabbits; indeed he seems to suggest that he is unsure why they have become so: 'I don't know when or why psychiatrists became Rabbits. Perhaps it was simply because I grew tired of misspelling psychiatrist'.⁷⁷ His reference to misspelling refers to his physical handicap following a stroke in which his left side become partially paralysed and the later physical side effects of an unknown drug regime. However, this explanation is too simple and Bishop's overall narrative (not to mention that it is his fourth publication) speaks to a more artful construction. Depending on who is asked the word 'rabbitt' can conjure up the image of a small ball of harmless fluff, or a voracious and devastating pest. The manner in which Bishop uses this term suggests something more akin to the latter. His usage is defiantly subversive and reactionary, and its comic presentation is definitely intended at the expense of the psychiatrists to which it refers. The comic masks, if only superficially the anger and hurt he feels. This anger is further reflected in the poem RABBITTS (see Figure 2, p.38), and in the short abstract, RABBITTS ON THE RUN. (see Figure 3, p. 38).

⁷⁷ Bishop, p. 74.

Figure 2: Rabbits

RABBITS

The snow has come deep and white
covering up the crap
but it still stinks
and I am trained to kill
I ruck savagely with my crampons
leaving blood to stain the snow

a shame I'm out of bullets
the glare hurts my eyes and once I struck a cow
that looked like a Rabbitt
Luckily I missed
but I got two does and all the babies
speared and trampled with my feet
in the next patch of bush
I wonder why they call them Psychiatrists
they look just like ordinary Rabbits
although some have big round eyes
I skin them warm
and rip out the beating heart and liver to check for pox
or feed the dog.
some take a long time to die
but not as long as the New Zealand White

Source: Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Roger Steele, 2000), p. 73.

Figure 3: Rabbits on the Run

Rabbits on the run

In this story I tell of the adventures of our hero as he escapes from the community to play with a friendly group of Rabbits on the side of a hill near Dunedin. With these Rabbits, he spent many happy hours telling stories and thinking up reasons for not going home. But it was with the little Rabbits, that he had most fun, He fell in Rabbitt traps, ate lots of yummy medications from the local shop, although sometimes these made him feel a bit sick. Once he strayed too far and got lost in the community, until a platoon of friendly policemen found him and took him back to his friends. Sometimes his pranks were too outrageous and he had to appear before a judge on several occasions. On the last time the judge said these Rabbitt games must stop, and from now on you must live in your own burrow in the community, like the rest of us.

So he did, because he didn't really like Rabbits.

Source: Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Steele Roberts, 2000), p. 72.

There are, however, two further, interrelated readings of his usage of 'rabbits' which are worth discussing. The first is related to the

reproductive notoriety of the animal itself. Bishop describes being seen by as succession of psychiatrists, five in total, all of which he sees as variations on a single dehumanising, uncaring theme. They literally breed like rabbits and when one leaves another relative takes its place.

The second has literary roots in Lewis Carroll's *Alice's Adventures in Wonderland*.⁷⁸ Lured into a strange, unfamiliar, and dangerous world by a white rabbit, Alice follows said rabbit to the mad hatters tea party where the guests talk in riddles. The similarities between the narrative and Bishop's are obvious. Initially agreeing to cooperate with the 'rabbitts' he finds himself in an institution where they talk around the issues and make little attempt to explain their actions. This world he has entered into is akin to the mad hatter's tea party, with the rules which govern interaction constantly changing. If these readings are correct then Bishop, in his substitution of 'rabbitt' for psychiatrist, is pointing out the 'evils' of the profession, in a subversive way, masking his anger with sarcastic humour.

In contrast to the use of figurative and emotive language, pathographers also use specific medical terminology, usually in relation to descriptions of diagnosis and treatment. Sarah G opens her narrative with the sentence: 'I was diagnosed as having chronic severe depression with significant anxiety components'.⁷⁹ She goes on to use terminology such as 'interventions', 'postnatal difficulties', 'impact on the foetus', 'controlled withdrawal', 'scheduled inducement', and 'monitored'.⁸⁰ In using this terminology Sarah demonstrates understanding of her own condition, strengthens the veracity of her narrative, and challenges the monopoly which the psychiatric profession exert over knowledge of mental illness.

The use of clinical terminology is especially significant when considering the testimony of mental illness sufferers because of the way it subverts

⁷⁸ Lewis Carroll, *Alice's Adventures in Wonderland*, illustrated by Alice B. Woodward and Sue Shields (London: Bell & Hyman, 1985)

⁷⁹ *Mums and Dads*, p. 4.

⁸⁰ *Mums and Dads*, pp. 4-5.

popular understandings of mental illness as being uncomprehending and incomprehensible; using specific psychiatric terminology ostensibly demonstrates the sanity of the pathographers. In another respect, however, its usage reinforces the power of psychiatric profession to control abnormality by diagnosing and labelling it. At the same time the use of clinical terminology can dissuades individuals from attempting an explanation of their personal perception and understanding of the manifestation of their illness; the narrative is distracted from more insightful descriptions of actual lived and felt experience (the strength of pathography), by the desire to be clinically accurate.

It is interesting to note the comparatively recent shift to such confident usage of psychiatric terminology; a shift reflecting growing awareness and greater empowerment of consumers. Kerry Davies asserts that the growing use of psychiatric discourse reflects the changes wrought by deinstitutionalisation, with the dispersion of power and the re-sighting of care in the community, and a shared illness identity for sufferers cemented by a common idiom, enabling meaningful and exclusive communication.⁸¹ The role of deinstitutionalisation in empowering patients beyond their physical freedom from institutional confines is undoubtedly significant. There is now an expectation of the psychiatric profession that clients will be fully informed about their illness and treatment, and patients themselves have been active in demanding this information and in using it and its specific language to authoritatively discuss their experiences.

It is important to consider the role of other influences, namely wider shifts in the general medical profession towards patient rights and informed consent, and the active pursuit of knowledge by sufferers. With greater access to this knowledge in various forms, such as the internet, support groups, specific illness charities and foundations, television commercials, campaigns and programmes, and an explosion of print materials, including pathographies, patients cannot help but be aware,

⁸¹ See Kerry Davies, “‘Silent and Censored Travellers’? Patients’ Narratives and Patients’ Voices: Perspectives on the History of Mental Illness since 1948’, *Social History of Medicine*, 14.2 (2001), pp. 267-92, at pp 284-90.

at least on some level, of their health, and the potential for illness. Arthur Frank sees this greater use of medical terminology by lay sufferers as indicative of our post-modern experience of illness. 'If modern medicine', he argues, 'began when physicians asserted their authority as scientists by imposing specialized language on their patients' experiences, the post-modern divide is crossed when patients ... can mimic this language in a send-up of medicine that is shared with the physician'.⁸² Taken further, patients use this mimicry to effect, peppering their narrative with terminology which legitimates and testifies to its truthfulness. In shaping their stories to fit the medical model, sufferers, make it use of the authority afforded. This shift has perhaps been most significant for mental illness sufferers, as beliefs about their uncomprehending state, and therefore the perception of informed treatment as a pointless exercise, are challenged. One final question, however, must be asked regarding such usage of language, and that is: does the use of clinical terminology denote understanding or is it simply mimicry of the doctor's explanations? And if it is the latter, is it satirically motivated, consciously done for the power and authority it affords, or turned to passively because of social expectation?

Sometimes language, especially in the form of a prose narrative, is not capable of accurately expressing the pathographer's perceptions of their experiences. In such instances sufferers look to diverse narrative strategies and media to articulate what has occurred. Still using a written form, Graham Bishop's pathography is remarkable for its use of poetry to tell his story. The therapeutic origins of the poetry tie in with the overall healing affects of the work, but it is in the self professed 'additional insight' which they offer into his experiences that they have most significance:⁸³ Some of Bishop's poetry is, in itself, reflective of his mental illness. 'The Strange Letter 2' (see Appendix 2) is notable because it is an alphanumeric poem. Bishop states:

⁸² Frank, p. 6.

⁸³ Bishop, p. 9.

The strange Letter 2 was written over the course of an hour or two. I had no intention of using numbers – they just came out...

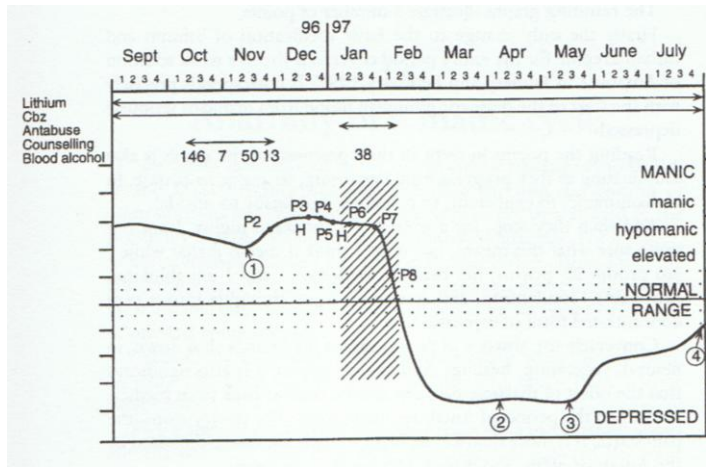
The poem is about a real event, when I was 22 and a friend and I shot 26 deer on the Shotover Face of the Matukituki, just upstream from Raspberry Hut. We ran out of ammunition and spent some time trying to shoot two of the last four deer with one bullet. So one part of the poem is about killing and the other part about loving. But the fascinating thing is that the lines sum to special numbers – the last line = 7 which is my birthday, 4 of the others are birthdays of 'significant others' to borrow some typical psychobabble. 22 has twice been my address. A friendly mathematician confirmed it couldn't be a random artefact – for it to happen I had to be calculating as I wrote – in [effect I] was thinking about two things at the same time.⁸⁴

Bishop sees this poem as a product of his unstable mental state – psychotic disturbances – in part induced by unknown medication. He writes: 'about this time I became aware that I was experiencing strange, brief, psychotic disturbances. They expressed themselves in various

⁸⁴ Bishop, pp. 110-11.

Figure 4: Anatomy of a Manic Cycle

Graph 1



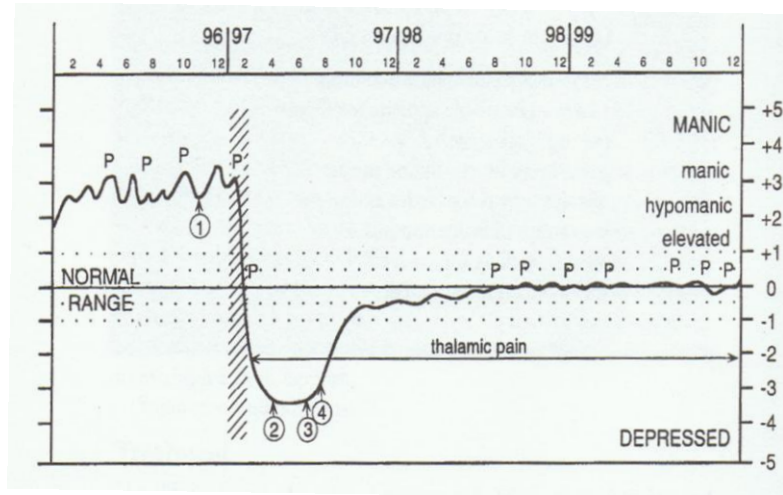
The upper graph shows the changes in my mood during the Wakari experience, and in particular the dramatic change that began during the period of Antabuse medication. The poems I wrote during this time provide considerable extra insight. P1 = Limits (9/96), P2 = Amanda* (22.11.96), P3 = Departure* (18.12.96), P4 = Suzanna* (15.12.96), P5 = Waiting for Godot* (26.1.96), P6 = The Strange Letter 2 (31.12.96), P7 = Now We Are Three (15.1.97), P8 = Soot (26.1.97), P8 = Death is a Cold River (2.97)

Poems marked * are not included in the book. I also wrote many other, but most are undated, so have not been used in the compilation. Although the upper curve has been shown as relatively smooth, my mood in December and January fluctuated quite markedly over periods of just a few hours, and sometimes hallucinated (H) in a gentle way.

Graph 2

The Lower Graph puts the Wakari experience in the setting of a 4-year period. The scale further emphasises the traumatising effect of the Antabuse medication on my brain, resulting in an eighteen month shutdown of my creative ability.

On both the graphs 1 = family conference, 2 = discharge, 3 = judicial hearing, 4 = home, P = poems



Source: Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Roger Steele, 2000), pp. 130-31.

ways – one was in the production of alphanumeric poetry'.⁸⁵ What is most interesting about the poetry overall, beyond the therapeutic nature and the specific mental evidence it affords, is the way Bishop uses them to map changes in his mental states. He graphs his mental state using the poems to show changes in his mood and in particular to show the effect of a specific drug which nearly killed him. The connection between the emotive poetry and the scientific graphs at first seems strange, and the accuracy of his graphs is no doubt scientifically debatable. But his use of poetry as direct evidence of his mental illness is original and suggests future possible avenues for elucidating the sufferer's perspective of affliction.

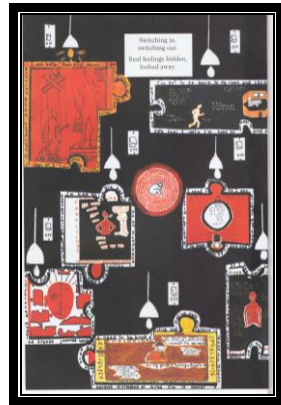
Suzanne Tocher's narrative is one of these, and remarkable, because it not only uses words, but also paintings to tell her story. While the paintings fulfil their traditional therapeutic purpose, in that they are a space onto which Tocher is able to visually project and release her thoughts and emotions regarding her illness experience, they also are collectively used to simultaneously narrate and explain these experiences (see Figure 5, p. 45). The paintings, which reflect the narrative of the written text, highlight the process of disconnection and eventual fragmentation that characterises Tocher's illness.

Taken collectively, the paintings are most remarkable because of the way they are used to tell her story. They obviously serve the purpose of therapy on one level; they are a space onto which Tocher projects her emotion and trauma. Regarding all of the images there are a few notable features. The first is the contrast between light and dark, and the clear parallels between her experiences. The extensive use of black has clearly negative and depressive connotations and the use of colour is an expression of healing. The second aspect is the theme of fragmentation and connection which runs throughout and is implicit in the title of the pathography itself. This is expressed in the jigsaw pieces and the

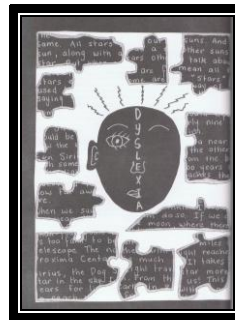
⁸⁵ Bishop, pp. 108-09.

shattered glass imagery, where the pieces are initially disjointed, coming together to complete a whole picture in the second to last image.

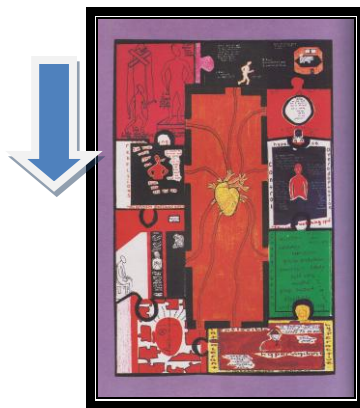
Figure 5: Suzanne Tocher's Paintings



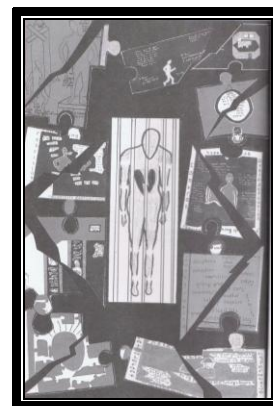
Switched In, Switched Out, p. 12.



Dyslexia, p. 18.



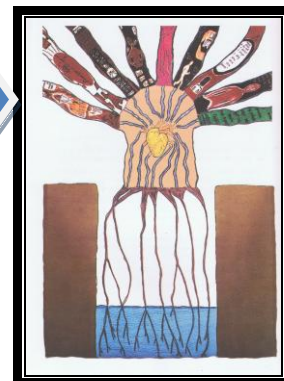
Heart Link, p. 56



Shattered, p. 44.



Sunrise, from mural, p. 49.



Well Connected, p. 60

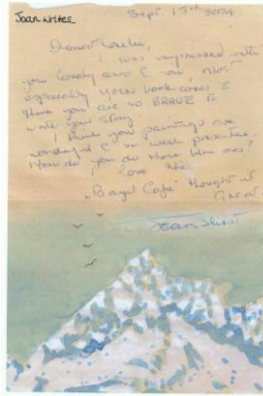
Source: Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington: Philip Garside, 2001), pp. 12-60. Reprinted with permission

If we read the images in this way the first image indicates that the puzzle is mixed up and there is a strong sense of foreboding, especially when contextualized by the text at the top which reads: 'Real feelings hidden, locked away'. The seeds of the trauma about to happen can be seen in the destabilized mental and physical environment. And the fear and despair that is conveyed in the central, encircled figure intensifies this feeling. The second image focuses on the author's dyslexia which further problematized her situation and is another piece of the puzzle. The third image is particularly powerful because it shows the moment of fragmentation, when the puzzle is broken seemingly beyond repair. However, the fifth image shows a rising sun which leads to the sixth of a completed puzzle; a whole image which though it still contains those aspects of her life which led to her fragmentation, shows that they have been ordered. The last image is particularly interesting, because it clearly extends the olive tree metaphor, with the deep roots which have found life sustaining water and the branches above which once again bear the weight of those contributing factors in her journey into mental illness. There is also a strong evocation of networks which are controlled by a central vital image, the healed heart, so important because without its life would cease entirely and because the heart as symbolic of emotions has to be reconnected for mental healing to take place.

While the inclusion of poetry, images and various other media is evidence of changing perceptions of narrative form, especially the multiplicity of mediums through which a narrative can be expressed, it also a reflection of changes in communication, most especially the increasing reliance upon and preference for visual information. Lorelei Burdett's pathography incorporates a range of visual media, including her own paintings, artwork by her daughters and nephew, letters, scanned images of hand written notes recorded while in hospital, a ward programme and hospital menu, and relevant articles from newspapers and newsletters (see figure 6, p. 48). However, unlike Tocher's narrative paintings Burdett's visual media is used to reproduce the experience not explain it.

More akin to artefacts, the various media are residues of the past which strengthen the reliability of the narrative's claims. The overall effect, especially in combination with the diary like entries which the narrative is structured in, is of a journal or scrapbook. Burdett is aware that reproducing the data in its original form is not only more authentic, it also enables her to communicate meaning through appearance; the notes function as a form or art in that their interpretation relies on their appearance. For example, her notes on pages (see figure 7, p. 49) allow the reader to see the way they have been written, including underlining, exclamation marks, variation in the size of the writing and the angle of it, and doodles (notably a sun, presumably indicative of happiness, certainly expressive of feeling). Perhaps most obviously, though, many of the notes are single thoughts, ambiguous, nonsensical, and reflective of the mental state they record, the reproduction of which would logically entail editing because of formatting constraints, and thus some of the meaning would be lost in translation.

Figure 6: Lorelei Burdett Media



Painting of the Remarkables letter, 2004 by Joan Hurst, p. 14.



Release 2004

Release, 2004, p. 114.



Underwater Sea Creatures 2001

'Underwater Sea Creatures, 2004 by my nephew, p. 33.

MANAKA WARD PROGRAMME - 27th MAY 2001				
DATE	TIME	LOCATION	ACTIVITY	REMARKS
27/05/01	10:00 AM	Manuka Ward	Reading about the Remarkables	
27/05/01	10:30 AM	Manuka Ward	Reading about the Remarkables	
27/05/01	11:00 AM	Manuka Ward	Reading about the Remarkables	
27/05/01	11:30 AM	Manuka Ward	Reading about the Remarkables	
27/05/01	12:00 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	12:30 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	1:00 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	1:30 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	2:00 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	2:30 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	3:00 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	3:30 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	4:00 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	4:30 PM	Manuka Ward	Reading about the Remarkables	
27/05/01	5:00 PM	Manuka Ward	Reading about the Remarkables	

Manaka Ward Programme, 2001, p. 78.



Drawings done at Hillmorton, 2001, p. 40

Positive Steps
HELPING YOU MANAGE BIPOLAR DISORDER

Welcome While one day having a mental illness may not be viewed any differently to a physical one, the reality is that currently stigma and discrimination can severely restrict the opportunities and choices in the community. In this issue, we explore some of the ways in which negative attitudes may affect you and what you can do to combat this discrimination (see page 4). Somebody who has confronted the negative reactions head-on is New Zealand artist, Lorelei Burdett (see story below) who has chosen to write a book to help others cope with bipolar disorder. We also include a compelling, personal account of a mother's love and care for her daughter with bipolar disorder and the "journey" they have taken together. You might like to pass this issue onto those close to you as we explore ways of tackling the different feelings, fears and experiences and include a story on how they can help you manage your mood swings.

Confronting the neighbours

As the mother of two girls, Lorelei was that it is a struggle against to discuss through family with family members. While her daughters, Sarah, 18 and Suzanne, 15 have been for bipolar disorder, meaning in some ways "artistic", they have been seen as "creative" and with the help of Lorelei's grandfather have come to terms with their mother's illness, the diagnosis and treatment. Then when the diagnosis is "her son", Lorelei was confronted with the lack of understanding their individual experiences and how they are living the most difficult times.

However, not all family members have been as understanding. Lorelei was part of the reason she has written the book is to help her parents and brother understand what she has gone through.

"In your daughter about the world being a bit crazy out to be acknowledged by them that are considered normal."

She has also experienced discrimination in the workplace, when a former boss rejected her in one of Lorelei's businesses and ceased communication.

"That really hurt - it was like getting a kick in the head and knowing it was the same person."

Lorelei says she has been lucky to receive the right treatment and medication with support and has nothing but praise for the health professionals, especially her grandfather who has been there for her every step of the way.

At 18 years old, she has a book to help others with bipolar disorder, a book that she hopes will help others who are struggling with bipolar disorder and help them to live the way they want.

"I really want there to be different to the stigma that makes someone be different or high school person and the stigma associated with people having bipolar disorder. The sooner they get help, the sooner they will be able to live the way they want. I hope that about the illness opens for those who want to live the way they want."

working at New Zealand Post as a retail officer but she is aware of the warning signs and knows to "slow down" if she feels stressed or tired. She is able to contact her doctor about the symptoms.

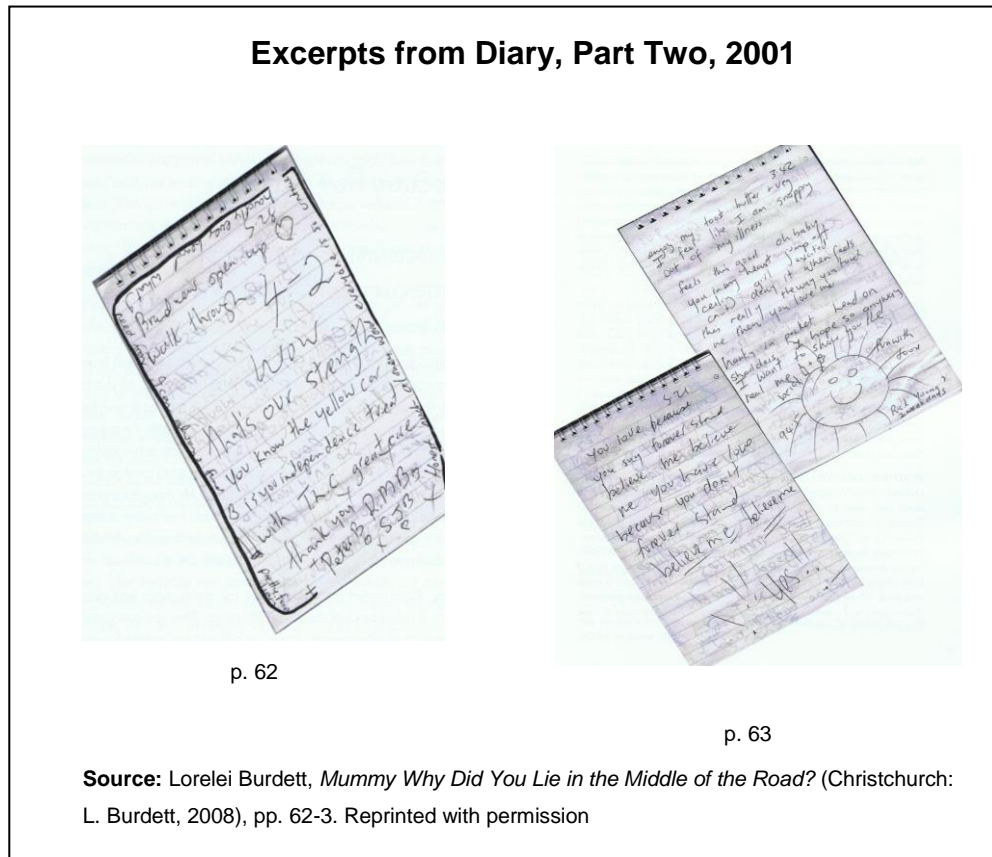
"My mental illness really distressed me and my family but I am now confident that I can and will cope regardless of the signs of anything going wrong again. Once I started to get help, even though we are not supposed to talk about that, but now I'm living with my family and friends, meeting new people and learning new things."

Photo: Sarah and Suzanne, Lorelei's daughters, create artwork during her time in hospital.

'Confronting the Neighbours', article from *Positive Steps*, Australian newsletter no. 4, 2004, p.125.

Source: Lorelei Burdett, *Mummy Why Did you Lie in the Middle of the Road?* (Christchurch: L. Burdett, 2008). Reprinted with permission

Figure 7: Lorelei Burdett Diary Excerpts



More spacious and varied, Burdett's pathography shifts between fonts and selectively uses capitalisation, ellipses, underlining, and boldness to express her unstable psychological state:

It's almost 7.45 and I am running a spa bath. It takes about 15 mins to fill but I take longer..... People in our state would not be able to comprehend the tasks we do without a thought are a great 'panic' effort. [...] **Creativity is a great healer**; hobbies, music, artwork, dancing, doing what you want to do. You own thing. **STRESS** causes the big 'C' **CANCER**⁸⁶

Visually more interesting, her greater use of space compared with the 'wall to wall' lettering that occurs in Kathryn Miller's and Ben Benjamin's

⁸⁶ Lorelei Burdett, *Mummy why did you Lie in the Middle of the Road?* (Christchurch, N.Z.: Lorelei Burdett, 2008), p. 45.

pathographies is less confronting, more effective as it holds the readers' attention longer and therapeutic in of itself because space is visually pleasing. A similar use of space can be found in both Suzanne Tocher's and Graham Bishop's narratives and is perhaps indicative of the financial factor which is changes in publishing constraints, both technologically and financially. With the growth of pathography as a genre and in its popularity, there has not only been more scope for publication, but also for more dynamic presentation. Most importantly the multi-media approach can be viewed as an extension of the therapeutic plot as it not only helps pathographers to better express what has occurred but also demonstrates the therapy which has aided their recovery.

This chapter has asserted that pathographers' narratives are important not only for what they say but because of the way in which they say it. Pathographers are motivated to write because they have something they wish to communicate; their purpose being most readily identified in the themes evoked. Many of the sufferers whose pathographies are examined in this thesis evoke the theme of institutionalisation to express their pain, outrage, anger and confusion at the treatment they have received in New Zealand psychiatric hospitals. In discussing the punitive, oppressive institutional culture, they also touch on the underlying themes of power and knowledge and boundaries and identity. Hierarchies of power are central not only to institutional experiences but are also apparent outside hospital walls, especially in the control of knowledge. The centrality of institutional experiences and the underlying culture of secrecy and dominance which characterised the treatment received are key aspects of the mental illness experience which pathographers discuss. They also emphasise the destabilising nature of the illness experience which involves not just the crossing of physical boundaries but also social and psychological divides.

The themes of the narrative shape its form as pathographers search for the best expression for their message. The structure of the narrative is

used to lend authority to the account and express, most importantly through the narrative frames the meaning of the events. In writing narratives of loss, battle, journey, rebirth, survival and self discovery pathographers therapeutically make sense of what has occurred and confer meaning on the events described. By examining these narratives we gain insight into patient perceptions of their illness and also the meaning which they attach to their experiences. Some of this meaning is conveyed through the language and media employed. By using figurative and emotive language pathographers convey what their experiences mean to them, and by using medical terminology they demonstrate their knowledge of their illness and also empower themselves and their narrative. Their use of multi-media is particularly interesting because of the way it aligns with the therapeutic function of the narrative. Additionally, the inclusion of poetry and paintings testify to the insufficiency of words alone to accurately convey what the pathographer feels. Sufferers craft their narrative to tell us about their illness experiences; what it felt like to be ill, and what it meant. Having considered how pathographers tell their narratives, in the next chapter I explore what pathographies tell about illness relationships. In particular I focus on how they challenge or confirm the dominant position of medical relationships, and examine what insight they offer into the role of family, friends and community in the illness experience.

Chapter Two

ILL-Connected: Relationships of Suffering

For sufferers of mental disorder, relationships are vital as the chronic nature of illness often demands long-term care. Within the last century, the balance of power has fallen authoritatively with the medical profession, yet the need for wider support, especially familial assistance, has not been entirely replaced; indeed, one might argue that in certain circumstances it has been strengthened. By examining these relationships we gain a more informed understanding of the illness experience itself.

This chapter examines the multiple illness relationships described by sufferers of mental illness in their pathographies. Divided into five sections, the chapter begins by looking at the relationships which exist prior to diagnosis, and which are primarily responsible for the identification of illness and seeking professional assistance. This is followed by an investigation of the often overlooked role of family and friends. As persons with the longest and closest associations to the sufferer, their role in the recovery process is important. How they react and adapt to the changes which their loved ones face can reveal much about the wider effects of mental illness. The next section discusses the traditional subject of medical relationships in an effort to understand the dominance of these associations. Whether positive or negative, they are greatly influential.

Following this, the chapter examines community relationships. Acceptance or rejection by the community reflects wider social and cultural values which underpin interaction, and express widely held understandings of sickness. The final section considers the interaction of these illness relationships, especially how they operate around the sufferer to meet varying needs. This chapter reveals the nature of the

relationships which arise between family, friends, community, the medical profession and the sufferer, and which make the illness experience, as Roy Porter observed, a 'complex social ritual'.⁸⁷

Pre-diagnosis Relationships

While this chapter primarily examines post-diagnosis relationships, it is important to briefly note the significance of those relationships which exist prior to, and which are frequently responsible for, the identification of mental disorder. As historians have shown, mental illness does not begin on entering a doctor's surgery or on committal to a hospital ward even though it may be labelled and clinical action taken to treat it.⁸⁸ Prior to this point, there has inevitably been some recognition of ill-health, prompting those concerned to seek external assistance. Pre-diagnosis relationships are perhaps best conceived of as a sub-group of family and friendship relationships as it is usually those closest to the sufferer who recognize changes in behaviour, and either encourage their loved one to seek help, or seek it on their behalf.

The pathographies show that in seeking advice and assistance, some family members of the mentally ill encountered medical resistance, their goal of securing treatment being frustrated by the need to convince 'authorities' of the validity of their claims. This was the case with Graham Bishop and his then wife Joan. Describing the symptoms of his hypomanic state, Bishop notes:

I also become much more articulate and quick-witted, and could easily convince most of my friends and colleagues, and on several occasions, separate psychiatrists, and sometimes even myself, that I was just feeling good. But some people always knew – my wife was one and it made it doubly difficult for her, trying to convince the experts while I was so

⁸⁷ Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), p 175.

⁸⁸ See Charles E. Rosenberg, 'Framing Disease: Illness, Society and History', in *Framing Disease: Studies in Cultural History*, ed. by Charles E. Rosenberg and Janet Golden (New Brunswick, N.J.: Rutgers University Press, 1992), pp. xiii-xxvi and Nancy M. Theriot, 'Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century', *Journal of the History of the Behavioural Sciences*, 37.4 (2001), 394-68.

eloquently reassuring them otherwise (and the experts were believing me!)⁸⁹

This excerpt highlights not only the difficulty sometimes faced in gaining medical recognition of illness, but also the role which family play in initially identifying it. However, medical scepticism, as Rosie Horton attests, is not the only source of resistance. Friends can, equally, be dismissive of concerns:

I would mention Robert's behaviour to friends and they would say 'Don't worry ... growing pains ... my son is revolting too', so you never get anywhere except to know that somewhere in an adolescent's process, they are going to be unlovable and impossible to manage.⁹⁰

Without reassurance from other family members or friends that suspicions of mental illness are well founded, an individual may not feel justified in seeking help, or even a second opinion. This highlights the influence of wider social and community values and beliefs. There is an expectation that teenagers will be difficult and therefore unusual behaviour is rationalised. For Horton to have sought further advice would have carried the potential of social condemnation; friends, family and those belonging to her wider social circle might have perceived her as being overly worried without justification.

However, sometimes family, by being so closely involved with the sufferer, fail to notice the symptoms indicative of mental illness, especially if they become personally involved in the sufferer's delusions. Over time, abnormalities can be rationalized and perspective lost; as was Catherine Platz's experience of her husband Gary's abnormal behaviour:

⁸⁹ Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Steele Roberts, 2000), p. 42.

⁹⁰ *Have No Shame; Kua e Whakama: Family Stories of Living with Mental Illness*, gathered, edited and compiled by Halina, Ogonowska-Coates (Christchurch: Schizophrenia Fellowship New Zealand, 2000), p. 13.

We all played a part. Anybody who visited would get caught up in these incredible conversations we were having ... really way out conversations ... but when you are in it, it doesn't feel that abnormal...

It was the flies. There were a couple of flies circling in the lounge and Gary had said that all the flies had been obliterated from Wainuiomata. It suddenly dawned on me that there were flies in the lounge and it was like I sort of came out of a trance. I think it is because we are so emotionally close that I got caught up in it. Most people are aware that their husband is going crazy but I really didn't know what was happening because I was so delighted that Gary was involved in something he was interested in, as he had been depressed for a long time.⁹¹

It would seem logical that such deception is more probable between spouses than between parent and child, as the nature of the latter relationship involves, to a degree, an assumption of guidance and care which affords greater scrutiny of behaviour. However, this does not necessarily mean relatives feel able to address the issue themselves. They may seek the aid of others, including mutual friends; especially if they feel that their involvement is more likely to result in treatment.

Additionally, friends are frequently afforded greater perspective because their distance from the individual is superior. Sometimes, as in Ben Benjamin's instance, they are among the first to notice changes in the individual:

I visited an Auckland psychiatrist a couple of times in the few weeks prior to going to Sydney. This I did as a favour to an Auckland friend and general practitioner, who said he was concerned about me.⁹²

In approaching Benjamin, was his friend expressing more than his individual concern? Had Benjamin's family asked him to do so, either because they felt unable, or because as a general practitioner they considered him more qualified for the task? Benjamin does not give us

⁹¹ *Have No Shame*, pp. 16-17.

⁹² Ben Benjamin and Ian Dougherty, *Out of My Mind: Living with Manic Depression* (Auckland: Tandem Press, 1994), p. 36.

any indication of whether this was the case, presumably because he is not privileged to such information.

Finally, the pathographies show that sometimes, as Margaret Wood recalls about her daughter Jenny, it is the sufferer who recognises their own illness:

I am amazed at my ignorance in those days.
I thought it was adolescence.
I think that Jenny really knew that something was wrong before I did. She was sort of making little hinting noises about psychiatrists and things.⁹³

The idea of self-recognition is significant because it challenges perceptions of mental illness sufferers as being uncomprehending. Also, the above excerpt illustrates how these comprehending sufferers may be delayed in their access to professional care by less perceptive family or friends.

On reading these pathographies, it is apparent that family and friends are of central importance in either initially recognising symptoms of mental illness, or conversely, failing to. This complexity remains apparent after diagnosis, and while the role family and friends play in the recovery process is by no means uncomplicated, it is significant.

Family and Friendship Relationships

Prior to the rise of the asylum in the nineteenth century, 'mad people', Roy Porter informs us, 'were a family responsibility'.⁹⁴ They cared for, sheltered and were primarily responsible for the actions of their 'lunatic' relations. However, the role of family, and that of friends in the illness experience has frequently been overlooked, its significance being eclipsed by a more visible medical presence. Families, recent scholarship attests, were central to discussions surrounding committal

⁹³ *Have No Shame*, p. 39.

⁹⁴ Roy Porter, *The Greatest Benefit to Mankind: Medical History of Humanity from Antiquity to the Present* (London: Harper Collins, 1997), p. 493.

and release from the asylum, and corresponded, often very emotively, with asylum officials about the welfare of their incarcerated kin.⁹⁵ The relationships which exist between a sufferer and their family and friends are especially complex, not only because they involve emotion, but because their closeness can sometimes negatively impact on the sufferer. Aside from recognising abnormality, the pathographies examined highlight the role of family and friends as advocates, carers, and supporters. Sadly, the narratives also reveal families as helping to cause the illness.

Many of the pathographies examined detail positive family relationships which provide both emotional and physical support to the sufferer. Most especially, they illustrate an active involvement in the recovery process. Whether this means seeking alternative treatments, providing a secure place to live, visiting the sufferer in hospital, or being there to console them and let them know that they are loved, the support of family is shown to be fundamental to the recovery process. Michelle Hughes recounts 'My parents visited me every day when I was in hospital and I was in there for months. And if I was ever really desperate to leave ... Mum would come and get me. They are wonderful people'.⁹⁶ The dedication of her parents testifies to the strength of their relationship with Hughes and to their concern for her wellbeing. The role they provided in offering an alternative to hospital care, when Hughes was unable to cope with the situation, highlights the mediating function of family.

⁹⁵ See: Coleborne, Catharine, 'Families, Patients and Emotions: Asylums for the Insane in Australia and New Zealand, c. 1880-1910', *Social History of Medicine*, 19.3 (2006), 425-42; and "'His Brain was Wrong, his Mind Astray": Families and the Language of Insanity in New South Wales, Queensland and New Zealand, 1880s-1910', *Journal of Family History*, 31, (2006), 45-65; Bronwyn Labrum, 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26 (1992), pp. 125-44; Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (Berkeley: University of California Press, 2006); Mark Finnane, 'Asylums, Families and the State', *History Workshop*, 20 (1985), 134-48; Barbara Brookes, 'Women and Madness: A Case-study of the Seacliff Asylum, 1890-1920', in *Women in History 2: Essays on Women in New Zealand*, edited by Barbara Brookes, Charlotte Macdonald and Margaret Tennant (Wellington: Bridget Williams Books, 1992), pp. 129-147.

⁹⁶ *Have No Shame*, p. 53.

Family also aid sufferers by seeking the best possible care. Ben Benjamin notes that on seeing the public psychiatric hospital in which he was being accommodated, his mother ‘arranged for me to be transferred to private care in the lush Northside Clinic.... Rozelle’s cream walls, green linoleum and urine stink were replaced by walls of white, carpets of blue and an antiseptic aroma’.⁹⁷ Her efforts to ensure that Benjamin receives the best available treatment, including initially flying to Sydney to be with him, highlight the financial and personal commitment made by many families. Similarly, the decision of Rachel’s parents to engage a ‘Fofa – Samoan healer’, when they found she ‘was not improving under Western Methods’ demonstrates a desire to aid in her recovery.⁹⁸ Rachel notes, ‘They flew him over to New Zealand from Samoa, and his specific purpose was to look after me’.⁹⁹ The second part of Rachel’s comment is especially important because it highlights the centrality of her welfare. In actively seeking an alternative to conventional treatment, Rachel’s parents’ significantly focus, not on the illness, but on her, as the person who is ill.

Additionally, family support sufferers by learning about their illness. This not only helps them to understand the illness but also informs them about how they can best help the sufferer to get well. Judy details, in the below excerpt, the significance of her family attending courses about her mental illness:

‘My sister went to a siblings course and my parents did a course to find out about schizophrenia. So they’re able to say whether a thought is sane or delusional. ... It has helped to take the fear out of the illness in a way. ... It allowed me to reach out to them and they can reach out to you’.¹⁰⁰

⁹⁷ Benjamin, p. 34.

⁹⁸ *Mums and Dads: Parents with Experience of Mental Illness Share their Stories*, gathered by Jack Perkins and edited and compiled by Darcey McDonald (Wellington: Mental Health Commission, 2005), p. 10.

⁹⁹ *Mums and Dads*, p. 10.

¹⁰⁰ *The Sun Will Shine Again: Stories of Survival and Optimism in the Face of Mental Illness*, gathered and compiled by Marguerite Fahy and Veronica Lysaght (Wellington: Schizophrenia Fellowship New Zealand, Wellington Branch, 1999), p. 20.

In learning about her illness, Judy's family not only allow her to feel more confident in discussing her symptoms with them, they also affirm the importance of her belonging within the family; she is important enough for them to make the effort to better understand her affliction.

As noted above, family and friendship relationships are complex because they involve a great degree of emotion. Investigations into nineteenth-century experiences suggest that emotion has always been a factor in negotiations between asylum staff and families. Catharine Coleborne has discussed the emotions that surface in asylum correspondence and patient case notes, and emphasises that family relationships are multifaceted and involve strong emotional ties.¹⁰¹

Significantly, this contradicts previous understandings of family as happy to have their 'mad' family members indefinitely incarcerated. The involvement of emotion is obvious in many of the pathographies examined, particularly in Suzanne Navart's narrative about her daughter Angelica. In the segment which follows she reflects on the range of emotions which she felt regarding her daughter's illness:

Later the impact of the mental illness told me I missed my well daughter, my daughter without the trauma of rape and delusion and illness. I felt a crushing sense of loss I wondered if the pain I felt, as I watched my ill daughter, could diminish. I wondered if I cared enough.... Memories searched through the many moments we had shared together and it was good to remember what she was like before everything went wrong. It hurt when everything went wrong.¹⁰²

Not only does Tocher express many of the key emotions which are attached to mental illness, including the pain, sorrow and sense of loss, which family and sufferer alike feel, she also draws our attention to the wider consequences of mental illness, which test, sometimes sorely, the endurance of family and friendship relationships.

¹⁰¹ Coleborne, 'Families, Patients and Emotions'

¹⁰² Suzanne Navart, *Tears of an Angel*, (Auckland: Suzanne Travan, 2000), p. 63.

The most serious of the consequences detailed is physical violence directed towards family – usually parents. Sarah Pokoati expresses remorse over having attacked her mother: ‘I feel especially sad over the way I attacked my own mother. My mother, my brother – I attacked them with knives’.¹⁰³ Similar violence is also recounted by Gary and his father Burt:

The events that led to Bert kicking Gary out were pretty harrowing. There was sudden inexplicable violence. Gary explains what happened. “Dad would be doing his own thing, just relaxing, He would be sitting there and all of a sudden I would hear something in my head and I use to say it out loud and then go and hit him.” Bert says, “He was quite frightening. He might start throwing things around and having tantrums. He was quite dangerous really. It got unbearable after a while. I couldn’t cope with it and I had to chuck him out.”¹⁰⁴

Jennifer Robertson has observed that violence was often the precipitating factor in asylum committal.¹⁰⁵ Family coped with abnormality in the home, often for many years, but when ‘mad’ kin became uncontrollably violent the asylum was their most likely destination. The above excerpts illustrate the serious and often inexplicable violence that family sometimes face as a result of a sufferers’ illness. Complicated by the fact that the violence is usually the result of mental delusions over which they have not control and cannot predict, family often, as Bert above attests, feel left with little option but to turn the sufferer out.

Often overshadowed by physical violence, the psychological consequences of mental illness are equally injurious. Linda Hughes recounts how innocent comments made by her daughter Michelle as a direct result of her disorder caused considerable anguish:

¹⁰³ *A Gift of Stories*, gathered, edited and compiled by Julie Leibrich (Dunedin: Otago University Press, 1999), p. 30.

¹⁰⁴ *The Sun Will Shine Again*, p. 9.

¹⁰⁵ Robertson, Jennifer, “‘Unsettled, Excited and Quarrelsome’: The Intersection of Violence, Families and Lunacy at the Auckland Asylum, 1890-1910’ (MA thesis, University of Waikato, 2006)

I used to come and say goodnight to her and I remember she said to me “Oh Mum don’t look at me because your face is so distorted,”
That was horrible.

I remember thinking “How am I going to cope with this?”¹⁰⁶

Psychological consequences are often more difficult to cope with than physical violence because family members are not in direct physical danger and feel obligated out of love and responsibility to endure the pain. Comments, such as Michelle’s, are especially upsetting because although they are a direct result of the illness this rationalisation only goes so far to mitigating the hurt which they cause.

Indeed, family are more likely than friends to endure the consequences of mental illness. Many pathographers detail the loss of friendships as a direct result of the disorder. Graham Johnson in particular emphasises the social cost of his illness and the motivation it has provided him with for remaining well:

Over the years my episodes have cost me a lot of friendships. People who just couldn’t stand it any more and couldn’t stand to have me around, even when I become well again. The memory of it is too painful. They still can’t have me around and it’s a real shame. That is one of the reasons I guess I make an effort to stay well.¹⁰⁷

Johnson does elaborate on what has occurred, but it is apparent that his abnormal behaviour has been responsible for his broken friendships. The fact that his friends can’t have him around despite his getting better, testifies to the pain caused by the suffering and in turn to the cost for the sufferer of their illness.

While friends may be lost as a result of the manifestations of illness, pathographers also indicate that the very fact of their mental illness is

¹⁰⁶ *Have No Shame*, p. 57.

¹⁰⁷ *A Gift of Stories*, p. 42.

sometimes responsible for the disappearance of friends. Graham Bishop notes, 'being sick or injured is acceptable, being nuts isn't. "Unwell" is the politically correct expression these days, but it doesn't alter the fact – former friends and colleagues don't want to know'.¹⁰⁸ As Bishop attests, stigma is often a barrier to maintaining friendships or forming new ones. It is therefore unsurprisingly that friendships are often formed with fellow sufferers. Diane comments: 'I've made some fantastic friends who are also consumers.... If I was ever in need of help I would definitely approach them first because I know they would tell me the truth and have my best interests at heart'.¹⁰⁹ In forming friendships with fellow sufferers, Diane and her friends create their own community, one in which mental illness is a strength.

Family can also impact negatively on a sufferer, especially via their involvement in recovery. Michael Leach's mother Nellie is critical of his goal to go surfing. While she may feel that she is only being realistic, the following excerpt illustrates how family can be detrimental to the recovery mindset needed to gain confidence and overcome illness:

Michael I'd just like life to be normal ... to do something realistic that I know I can achieve. I'd be surfing ... exercising ... working ... that has been one of my goals.
...
Mum says that I shouldn't surf so I might stick to the painting!

Nellie I say "You're too fat now Michael."
I went out there with him and he couldn't get out to the Waves ... and then he broke the board....

Michael It wasn't even my board ...!
It's been a hard time eh Mum. I don't even really know how hard it had been for Mum and the family.¹¹⁰

¹⁰⁸ Bishop, p. 78.

¹⁰⁹ *Mums and Dads*, p. 21.

¹¹⁰ *Have No Shame*, p. 9.

Nellie's comments only serve to reinforce to Michael how much his illness has cost him by negatively construct that illness in terms of failure. They also reflect on how family members can undermine the recovery process. Her negative response rather than constructive criticism, and Michael's apologetic stance leads one to question the lasting nature of his mental recovery.

In addition to negative experiences related to recovery, some pathographers detail instances where family and friends can be directly linked to the cause of their mental illness. The following excerpt illustrates how family tension contributes to Lorelei Burdett's breakdown during a family holiday:

There was constant tension between Mum, Rosanne and my nephew, which resulted in a non-relaxing trip. We arrived at the motel and I suggested we go to the Ranch for dinner. "No", according to Mum it was too dear. She had been unhappy with the cost of the tour to the Milford Sound and the glowworms at Te Anau. In fact definite resistance, as she became agitated and made a scene at the Te Anau tour booking office. It proved too much for me!¹¹¹

The constant atmosphere of tension which triggers this particular attack of Burdett's bipolar disorder is, it appears, one of an ongoing series of incidents in which Burdett feels stressed around her mother; this stress compounding the strain on her delicate mental state. The tension also appears to be symptomatic of the underlying cause of her illness. She remarks: 'My parents never wanted me to marry (high expectations). Don't get pregnant...what? No children – just work!'¹¹² This comment suggests that part of the cause of her illness is the sense of disapproval which her parents convey – Burdett can never be good enough. She fails to measure up to their expectations, and this feeling of failure leads her to not be able to cope.

¹¹¹ Lorelei Burdett, *Mummy Why Did you Lie in the Middle of the Road?* (Christchurch: L. Burdett, 2008), p. 32.

¹¹² Burdett, p. 24.

Similarly, Suzanne Tocher also highlights influence of family in the development of mental illness. In describing the militaristic trauma of her upbringing she draws implicit links between her father's abnormal behaviour and her own mental illness:

The war, combined with his background, caused him overwhelming trauma and loss. His only way to cope was to control. Our family took on the structure of the military as he re-enacted his trauma.¹¹³

Fear of her father's unpredictable behaviour and the daily pressure she faces by being under almost constant surveillance causes the onset of her schizophrenia. While Tocher can rationalise this experience, seeing the underlying issues in her own father's life, it is apparent that the influence of family is not always positive.

The same is also true of the influence of friends. Angelica Navart emotively recounts how her friends were responsible for her schizophrenia. On a night out Navart's 'friends', spike her drink and as a result of her incapacitation she is raped. The trauma of this event and the extreme sense of betrayal which Navart feels causes the onset of paranoid schizophrenia:

I felt disgusted with everybody, all my friends, whom I thought were friends. I always understood that friends, real friends, did not harm you, did not place you in a situation where you had no control. I felt angry and betrayed. I felt a deepening hurt and as I began to think about this hurt I began to distrust everything I once believed in.¹¹⁴

The actions of her friends cause Navart to question everything which she once took for granted. The emotional turmoil which this event generates is apparent, and the overwhelming sense of distrust that prevails paralyzes Angelica leaving her unable to cope.

¹¹³ Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington: Philip Garside, 2001), p. 9.

¹¹⁴ Navart, pp. 10-11.

Whether positive or negative, family and friends play an integral role in the illness experience. Their love, care, advocacy and support, or their betrayal, criticism, and abandonment, arguably exert greater influence over the course of a sufferer's illness than the medical profession.

Medical Relationships

Of the relationships which feature in the investigated pathographies, those which exist between the patient and the medical profession are the most prominent. Formed during or after diagnosis, medical relationships are most obvious because they are clearly delineated by time and space. Illness, now so closely bonded with scientific medicine (the latter being perceived as *the* solution for the former) inevitably requires some form of medical intervention and thus some form of relationship. The necessity of these medical relationships is the result of an inequality of knowledge. Collectively we know more about the body, yet individually our bodies have become a mystery, belonging to the realm of graphs, charts, diagrams, results, scientific terminology and, most consequently, physicians. This is especially the case, Rob Smith notes, with sufferers of mental disorder: 'Twentieth-century society has delegated the psychiatrist to communicate with the mentally sick – there is no longer a language common to the rational and the insane'.¹¹⁵ In Western culture at least, sufferers and their families and friends now understand illness in terms of disease, medication, and scientific discovery.

For sufferers of mental disorder medical relationships can be beneficial, supplying medication and therapy which help to lessen the symptoms of illness. Aligning with the professional, beneficial image officially projected, some pathographers recount positive experiences of medical intervention. Wendy's narrative of her institutional experiences in both Hastings hospital and Sunnyside is a predominately positive one:

¹¹⁵ Rob Smith, 'The Muted Voice: Language as a Straightjacket in the New Zealand mental Institution', *Journal of Sickness, Health and History*, Special Issue Interpreting Institutions: New Zealand Histories, 1930s-1960s, November (2002), p 107.

I think that the value of the institutions is that they allow people to do what they want to do – when, where, how – because they have people who know how to set limits and they have mighty strong walls. Because sometimes there's a lot that needs to come out. I needed to feel contained and, in retrospect, the sound of the solid key turning in the lock was a good thing for me.¹¹⁶

The security afforded by the institution is for Wendy a positive thing. The solid locks and strong walls of the hospital allow her to feel safe and contained. The idea of containment is an interesting one because it suggests that Wendy does not feel in control of her own actions, offering insight into the reasons for her committal. The idea of containment is strengthened by her emphasis on the positive influence of the boundaries and routine which the institution supplies; having set limits provides her with a needed understanding of acceptability.

While Wendy is not alone in her praise of institutions, significantly most of the other positive accounts are related to private psychiatric hospitals, in particular Ashburn Hall. Ben Benjamin attributes Ashburn hall with playing a key role in his recovery and has positive memories of his time there:

Ashburn Hall was established in its farm setting in 1882 and is one of the finest therapeutic hospitals in the Southern Hemisphere. It felt less like a psychiatric hospital and more like a private hotel with medical facilities attached. The staff were part of the ward, mixing with the patients, as opposed to the arm's length approach I had experienced at the other psychiatric hospitals. It was the only psychiatric hospital where I felt I was being treated with love and compassion. A therapist was always there to monitor my progress. If I was feeling things were getting on top of me and I did not want to be part of anything anymore, I could go to my room and rest for a few days. There was always a member of the nursing staff available around the clock, to talk to during a sleepless night or to give me some medication because my body was feeling totally off the wall.... Ashburn Hall was a kind of sanctuary....¹¹⁷

¹¹⁶ *Shadows and Silence*, narratives gathered, edited and compiled by Clare Goodwin (Wellington: Steele Roberts, 2004), p. 36.

¹¹⁷ Benjamin, pp. 91-2.

Benjamin's description is notable for its use of emotive language. 'Finest' 'love', 'compassion' and 'sanctuary' all convey a positive opinion of the care which Ashburn Hall offers. It is apparent from his observations that in order for treatment to be positive it must be focused on the patient's wellbeing. However, Benjamin's comment that 'it was more like a private hotel with medical facilities attached' is especially important because it and reminds us of the private nature of the care and that such treatment comes at a cost which limits its benefits to the more economically fortunate among sufferers.

Although positive experiences of institutional care are illustrated by the above perspectives, far more frequently it is individual staff or psychiatrists and doctors who are viewed in a favourable light, rather than the system collectively. As discussed in Chapter One, the inclusion of forewords by a psychiatrist or other mental health care professional is evidence of a positive relationship; exclusion could indicate the opposite. Additionally some pathographers make reference to the positive experiences they have had with institutional staff and psychiatrists. In the following excerpt Wendy reflects positively on staff at Hastings hospital:

A vivid memory I have of the place is of the staff. There were really great male staff and female staff. I think in psychiatric nursing you get such strong, good people. They have such clear roles. I felt a very strong presence. I'm sure that's a quality I needed to feel.¹¹⁸

Strength is a key factor in Wendy's positive remembrance. As with her above comment about the institution, it seems that the strong presence of staff provides her with definite boundaries and security; two factors which she identifies as being important for her recovery. Similarly, Graham Johnson praises the role of his doctor in his recovery:

¹¹⁸ *Shadows and Silence*, p. 34.

I had a really good doctor, Alison Brown, who was able to get my confidence and assure me that it was only transient memories that I would lose. I wouldn't lose deep-seated memories like the memory of my daughter or my family or major events in my life. So I agreed to have shock treatment.¹¹⁹

While Johnson's description of his doctor as 'really good' is largely a reflection of the positive outcome of his treatment, his comments about his doctor gaining his confidence, and offering reassurance and information about his treatment are significant. They reinforce the importance of personal interaction between patient and psychiatrist as being essential elements of a positive relationship. Conversely, a lack of interaction and explanation and are among the numerous negative experiences which pathographers recount.

Negative medical relationships are more prolific than their positive counterparts, usually because their recollection involves feelings of anger, pain, embarrassment and despair. Many of the painful experiences recounted by pathographers relate to institutional treatment. A highly stressful site, the psychiatric hospital, as Denise attests, is place where abnormality seems to be magnified, not mitigated:

They committed me to Tokonui, and that was the worst, worst, worst thing. For a start I was taken straight into an isolation unit, and I was strapped down until I was in a side room. Of course we were going through the rigmarole of having to strip naked – and if you don't do it, they'll do it for you sort-of-thing – and not being allowed to be left in your knickers or your socks or anything like that, and being left in this place....

I had quite a serious cut on my leg and it was going septic. I ended up having to scoop the pus out of it with a plastic spoon they gave me to eat with, because they didn't let me see the doctor. But if you read the notes now, they said that I refused to see a doctor....

After a few days I managed to get out of isolation, into the main ward, In the main ward, we were locked into the dorms, There was a woman lying there in full light – there was a light

¹¹⁹ *A Gift of Stories*, p. 46.

outside the windows so you couldn't get any darkness or peace at night, but this woman was lying there masturbating, which was quite frightening for me at that stage. There were no doors on the toilets and the men and women used the same area at times. Every body had to have showers at the same time, so they'd only use one shower, and all the women would go in, and then all the men would go in. I felt very unsafe that there were no doors on the toilet.¹²⁰

Denise's account graphically details the lack of privacy and humanity which characterise her experience of Tokanui. Like other pathographers, she mentions having to strip naked and perform acts of personal hygiene without privacy, this leaving her feeling exposed, unsafe and frightened.¹²¹ Many of these practices run counter to social expectations of decency and to the normalising aims of the institution. Instead of being a place where normalcy is exemplified, Denise's account depicts the institution as a place where abnormality is fostered, to the detriment of patients and staff alike.

Graham Bishop's pathography is especially critical of what he sees as the dangerous and harmful system of care which psychiatric patients have to endure in psychiatric hospitals. The following excerpt details his attempts to gain proof that he was being medicated at night without his knowledge while he slept:

The last thing I expected in 10D was to find a sinister side. My room could be locked from the inside, by turning a locking bar into a horizontal position so it formed a ledge. However it could also be unlocked, quite quietly, from the outside with a key, which caused the bar to rotate to a vertical position. After a while I began to have an uneasy feeling someone was coming into my room during the night. I was sleeping much more deeply than usual; normally I would have been awake instantly even if I had taken a sleeping pill, so I took to trying to set an indicator that would be disturbed if the door was opened. The markers were disturbed several times, but I could never be quite sure I hadn't done it by myself by blundering out bleary-eyed for a leak. I removed that uncertainty by installing my own en suite, in the form of a suitable receptacle. And finally my suspicions were confirmed. I had taken to placing a peppermint on the locking bar. This particular morning the peppermint was still in place,

¹²⁰ *A Gift of Stories*, p. 35.

¹²¹ See also *Shadows and Silence*, p. 16.

but both it and the bar were sticky. I had apparently been disturbed and the intruder had to improvise a way (by spitting on it) of making the mint stay put while he or she relocked the door.

At about the same time I noticed some crusted blood on my arm. A was still sleeping in my sleeping bag, but I always had my forearm out. I new I had not cuts or scratches so I was puzzled. However one of a geologist's tools of the trade is a magnifying glass, and I had mine with me. Carefully I sponged the dried blood away, and what I found sent shivers up my spine. It was undoubtedly a puncture wound, a neat little round hole such as a hypodermic would make.¹²²

This incident is particularly disquieting on multiple levels. Not only does it expose the duplicitous and unethical practice of medicating patients without their consent or knowledge, most disturbing because of the realisation that many sufferers would never be aware of it happening, it also highlights, via the 'sticky peppermint incident', the culture of secrecy which underpins institutional treatment. Bishop's account is most unsettling because it is a rational and reasoned account. Instead of making embellished and unproven claims, he seeks proof for his suspicions and details the process which he follows to obtain it.

While the institution is the most conspicuous site of negative experiences, Kathryn Miller's pathography demonstrates that relationships with private psychiatrists can be equally harmful. In the following excerpt she details how following her final session with 'the doctor' he suggest that his therapy has been misdirected:

He smiled at her as she left, as usual, he stood holding the door open for her, "cheer up," he said, "it's only for six months." "I must have had "THE WRONG THEORY". When you come back we'll try another one," and the door closed behind her.

Kathryn stood for a minute trying desperately to understand the words she had just heard.

The wrong theory! Did that mean that everything she had been told for the last seven years, had been wrong.¹²³

¹²² Bishop, p. 107.

¹²³ Kathryn Miller, *Kathryn* (Rotorua: Tancred Press, 1984), pp. 113-14.

The doctor's comment that he 'must have got the wrong theory' and that he will 'try another one' when Miller comes back is shocking not only because it infers that the doctor is operating on the premise of trial and error, but also because his attitude shows little regard for Miller's wellbeing; she is just a 'theory'.

Like family and friendship relationships it becomes apparent that the nature of medical associations is dependant on the individual parties involved, with both positive and negative experiences recounted. However, negative relationships are more frequently recounted than positive ones, perhaps because anger is a greater motivation to write than praise. Many of the negative experiences recounted are scandalous in their depiction of inhumane and unethical treatment, emotively demonstrating the suffering which has been endured. Medical relationships and responses to mental illness are in part dictated by the wider social context to which they belong. The next section examines the role of community in the illness experiences and considers how they shape attitudes towards abnormality.

Community Relationships

Community involves the concept of collective identity, in a way that the other, more individualised, relationships do not. It is a broader relationship which encompasses a sense of belonging that goes beyond the sufferer's immediate situation. Unlike the other two groups, the community does not necessarily have a direct association with the sufferer.

Community functions on more than one level. There is the physical reality of living amongst people linked by a shared situation, and then there is the ideological influence, whose imprint on the sufferer, family, friends and the medical profession influences perceptions of mental illness – its causes, its treatments, and the place of sufferers within the community. Sarah Pokoati highlights this when describing specific Island community responses to mental illness:

I think Islanders think it only happens to Pakeha, it doesn't happen to us. When it does happen they say, *Oh Christ, she's a nutter*. Cook Islanders are very ignorant. They Think you're Crazy. *You belong in a nit-house, you don't belong to us. You should be with people that are like you.*¹²⁴

Regardless of whether this is actually articulated, her absorption of these popular beliefs reflects the ideological influence which community exerts on illness experiences.

Socially and culturally constructed, madness is not a static term; its definition is constantly being redefined, to reflect current communal fears and anxieties. Laurie Gluckman's investigation into early Auckland deaths is an excellent example of the role community plays in ascribing mental illness as the cause of death, thereby defining its character.¹²⁵

The definition which society develops reflects collective views about treatment – what is to be done with the mentally ill from a community perspective. The answer usually reached is how best to protect the community from the perceived dangers of the mentally ill.

The role of society in dictating the boundaries of abnormality cannot be underestimated. Behaviour which is defined as abnormal varies between communities and cultures. Susie Crooks' narrative is an excellent example of this:

I went to Sydney when I was fifteen and started having psychotic episodes, very similar to the experience of taking LSD, but I didn't need the drugs. Because I was living in the Cross with a lot of drag queens and prostitutes and very colourful, tolerant people, I never go diagnosed, and I was

¹²⁴ *A Gift of Stories*, p. 28.

¹²⁵ Gluckman's records show that neighbours, friends, and family were often *the* source of information regarding the mental state, prior to death, of an individual. 'Verdicts of lunacy reduced the stigma associated with suicide, which was both a moral and criminal offence in the nineteenth century' (p. 105) Given this, it is likely that the authorities were willing to believe the testimony of acquaintances, however remote. The perception of what constituted mental illness was socially and culturally constructed by community understandings, which in turn were reflected in legal matters. See Laurie Gluckman, *Touching on Deaths: A Medical History of Early Auckland Based on the First 384 inquests*. (Auckland, N.Z.: doppelganger, 2000)

accepted. I would just go off and they would just say, *Oh that's Susie going off*. I wouldn't sleep for a week. They looked after me but they didn't judge me.¹²⁶

In Crookes' community of drag queens, prostitutes and drugs, unusual behaviour is to a certain extent the accepted norm, her abnormality was tolerated and absorbed into the circumstance of daily life.

Fear has frequently driven community responses to mental illness. Prior to the development of asylums, mentally ill persons might find themselves treated as criminals and detained in jails along with other social misfits, and still earlier they might be driven out of their village or community because their illness represented deviation and unpredictability. Picked up by police and charged with being "idle and disorderly" Brian C. Hare was placed in prison for a total of three weeks without proper assessment of his mental state. While being held he was physically punished by guards for making noises in the night:

The screws- three of them came bolting into my room one morning and accused me of being rowdy during the night. I was shaking with fright afterwards and the beating was severe enough to paralyse me down one side....
A week in Tauranga when it was obvious I was acutely unwell and in jail again (Waikeria adult remand) and being given a bad hiding by the guards for crying out in the night.¹²⁷

Attempts in recent years to combat the prejudices, stigma, and discrimination of society have had some, but many sufferers would say limited, success. It is clear that mental illness still unsettles many within the community and this can make it hard for the mentally afflicted to rebuild their lives.

Sarah Pokoati notes the difficulty faced by many diagnosed with mental illness in attempting to obtain employment:

¹²⁶ *A Gift of Stories*, p. 10.

¹²⁷ Brian C. Hare, *Peregrinations of a Priest: An Autobiography of a "Nobody"* (Paekakariki, N.Z.: Earl of Seacliff Art Workshop, 2006), pp. 25-6.

I'm also being helped by Focus Trust, who try and find employment for people with disabilities. I find I've been knocked back on some of my interviews because of my mental illness. There were a couple of jobs I applied for and never got, although I was qualified for them. I've got a CV which shows the jobs I had before I was ill and it shows my educational qualifications. I think the boss was prejudiced because I have schizophrenia.¹²⁸

Prior to the move to community care most sufferers found employment within the grounds of the asylum. Mainly sited in isolated locations, the asylums were designed to be self sufficient, with patients working to maintain the wards and the grounds in what was then labelled moral therapy; a form of treatment designed to reaffirm gender roles and instil appropriate behaviour as dictated by the community. In particular, this included an emphasis on hard work, for many dismissed mental illness as the result of fecklessness. Asylums became communities of the mentally unwell, a distinct group divorced, to perhaps the greatest extent, from society. The growing awareness of mental institutions as self-contained communities was reflected in asylum planning, with perhaps the best example of this being Cherry Farm. Opened in 1952 the site was developed to mimic outside life with shops, a post office, bakery, chapel, school and library of its own, all of which were run with the labour of inmates.¹²⁹

With shifts in official attitudes, the seclusion of the mentally ill became less popular, and attempts were made to integrate asylums with their surrounding communities including encouraging family and friends to make visits and organising excursions into the surrounding area. Waltraud Ernst notes some of the early activities which occurred. However whether these were solely for the benefit of patients appears debatable:

¹²⁸ *A Gift of Stories*, pp. 29-30.

¹²⁹ Also see Warwick Brunton, *Sitivation 125: A History of Seaview Hospital, Hokitika and West Coast Mental Health Services, 1872-1997* (Hokitika, N.Z.: Seaview Hospital 125th Jubilee Committee, 1997). Photographs reveal multiple functions, and outings, including picnics and Christmas parties.

Amusements and attendance at church services were less frequently organised during the early decades, yet became increasingly part of asylum life towards the end of the century. By that time asylum functions were patronised by the local elite, as it had become fashionable, in New Zealand as much as in other colonies, to become involved in events supposedly put on for the benefit of the poor and distressed. Sometimes concerts were organised under vice-regal patronage, and 'gentlemen from town', 'respectable citizens', 'the ladies of Christchurch' or simply the 'fashionable' would venture inside the normally impenetrable asylum compound. On special occasions tranquil patients were allowed to participate in excursions.¹³⁰

While visitors were encouraged, it seems that other than dedicated family there was little contact with the community beyond the walls. Natasha, a patient at Cherry Farm Hospital in 1975, notes that 'people were terrified of coming to a mental institution to visit people, so they didn't come'.¹³¹ Policies developed by government to address the shortcomings of mental health provisions and the stigma associated with mental illness have led to campaigns promoting wider awareness. Charitable organisations have also been established, such as the Schizophrenia Foundation, which provide information and support to family and sufferers.

Despite this drive to reduce stigma and discrimination and demystify mental illnesses, very few of the pathographers refer specifically to positive community responses, except when acknowledging the support of organisations such as the Schizophrenia Foundation. More frequently they recount negative experiences of exclusion, inequity, and intolerance. However, one potentially positive story worthy of note is Kathryn McNeil's account of public responses to an article she wrote for the Christchurch *Press*:

¹³⁰ Waltraud Ernst, 'The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes', in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, edited by Linda Bryder (Wellington, N.Z.: Bridget Williams Books, 1991), p. 82.

¹³¹ *Shadows and Silence*, p. 16.

I wrote an article about it in *The Press* in 1993 and five years later I still get stopped by people in the square who say, *You wrote that article on depression*. You know, I'm famously depressed!

The other thing that happened was that all these people came out of the woodwork at *The Press* saying, oh, I got that too, you know, or, I've had a terrible time with depression, and as soon as they say it you know that they have.¹³²

Clearly her article, afforded *The Press* community, and indeed the wider public, the opportunity to discuss mental illness. Whether their identification of her as the person who '*wrote that article on depression*' was intended as complimentary is somewhat ambiguous. But if we assume it to be positive, it becomes apparent that the bravery of individuals to disclose their illness may result in positive reactions.

The relationship between patient and community is critical in defining what constitutes mental illness. And this influence extends across all the other relationship groups. The next section therefore explores not just how community interacts with the others groups, but also how the others interact with each other, to shape the illness experience.

Interaction

While the chapter has looked at the nature of the various illness relationships formed between the patient and their wider social context, it has done so by examining these relationships in isolation. This does not accurately reflect the reality of the interaction which takes place, as it fails to acknowledge parents and friends conversing with psychiatrists, or community groups aiding families to support their loved one. This section looks at the negotiations, detailed in the pathographies, which take place involving family, friends, the community and the medical profession. The nature of their interaction is important because it informs us about the hierarchies of power that underpin, and are fundamental to, our conceptions of ill health.

¹³² *A Gift of Stories*, p. 22.

Positive instances of cooperation and informed care are most obvious in pre-diagnosis relationships, where family work with friends, the community and the medical profession to obtain help for the sufferer. Following a previous failed attempt to get him to go to hospital, Ben Benjamin recounts how in response to anxious calls from neighbours about his disturbing behaviour his mother turns up with additional support:

In walked my mother, my sister, my brother-in-law, my general practitioner, my doctor friend and five policemen. The sound of breaking glass and the sight of me convulsion on the floor had prompted a neighbour to call my mother, who in turn had sought wider help.¹³³

The serious nature of the incident is evidenced by the fact that Benjamin's mother enlists the help not just of family and friends, but also that of the medical profession and the police. Interaction of this nature is commonly recounted as family seek external answers and assistance for abnormal behaviour, especially when faced with resistance by the sufferer.

Positive interaction is also detailed in the pathographies when recounting instances where family are kept informed of their loved one's condition. As Kathleen Rushworth attests regarding the information she was given about her son: 'They said he was on medication and it was keeping him very quiet. ... The doctors were very good'.¹³⁴ Similar sentiments are expressed by Rosemary: 'the psychiatrists who treated Angie in Auckland, and Wellington after she overdosed, were wonderful. They told us to get in touch with the Schizophrenia Fellowship "and that's what helped"'.¹³⁵ Effective, open communication is shown to be the foundation of positive interaction.

¹³³ Benjamin, pp. 53-4.

¹³⁴ *Have No Shame*, p. 32.

¹³⁵ *The Sun Will Shine Again*, p. 6.

Conversely, many pathographies highlight the frustration which families feel over the difficulty which they face in communicating with psychiatrists and doctors, especially where the individual in question is an adult and information about their condition is 'privileged'. Rob and Dianne highlight this difficulty when describing their interaction with the doctors and nurses regarding their son William's condition:

One of their biggest struggles was coping with the doctors and nurses.

"We felt like bunnies," says Rob, "like the village idiots. They didn't seem to take notice of us, the parents."

Dianne agrees: "I'd try and talk about something that was worrying us and I'd get a lecture on the Privacy Act and how I wasn't supposed to be discussing things behind his back."¹³⁶

Rob and Dianne's experience emphasises the power imbalance which exists between lay sufferers, their families and the medical profession. The interaction which occurs between the relationship groups is primarily driven by the different nature of the relationships. It is therefore not surprising that much of the interaction described, or alluded to, in the pathographies details conflict. For example, Rosemary, describe having to fight to get the best care possible for her daughter Angie:

"I had to fight to get Angie up to the Starship Hospital in Auckland because they wouldn't put her on Clozapine here," Says Rosemary. "Then when we did get to Auckland there was a hassle about which health organisations would pay for the drug."¹³⁷

The balancing of different priorities and obligations is often at the root of much confrontation, as is seen here where Rosemary's efforts are frustrated by the constraints of the health system.

¹³⁶ *The Sun Will Shine Again*, p. 29.

¹³⁷ *The Sun Will Shine Again*, p. 6.

Disagreement between medical professionals was a surprising aspect of conflict to arise. Kathryn Miller describes asking a psychiatrist whether he felt that her previous 'doctor' should still be aloud to practice:

I'm worried that the first doctor I went to is still practicing. Do you think he should?

...

No I don't, he said.

Kathryn was surprised at this. Not often did she ever hear a therapist criticise another.¹³⁸

We share Miller's surprise as professional criticism is not something that is engaged in lightly. While Graham Bishop does not directly witness confrontation between staff he does note the inconsistency with which they administer his 'care':

One nurse in particular would often countermand arrangements made the previous day with one of the more qualified staff on the basis of that he read my leave conditions differently, but he would never let me see the file....

On another occasion he told me I was restricted to one phone call a day. None of the other seemed aware of this restriction.¹³⁹

Whether this staff member would have directly challenged other staff members is debatable; it seems more likely, as Bishop suspects, he was playing games because he knew he could not easily be caught out, after all who would believe the word of someone who was mentally ill. He need only state that Bishop was wrong.

Regardless of the nature of the interaction between the various illness relationships, it is important to recognise the complex and multi-layered nature of illness experiences. The medical profession do not simply treat the sufferer; they must also negotiate with family about the nature of the treatment they prescribe. In turn, families frequently seek information about their loved ones and express their dissatisfaction with what they

¹³⁸ Miller, *Injustice*, p. 98.

¹³⁹ Bishop, p. 85.

perceive to be poor care. Additionally, each group also engages with the community either directly or, more implicitly, through the beliefs and understandings imprinted. Therefore, we observe that the recovery process involves more than a single sufferer and their psychiatrist.

This chapter has demonstrated, through an examination of the illness relationships detailed in the pathographies, that ill health involves a complex series of negotiations between the sufferer, their family and friends, the medical profession, and their community. The centrality of family and friends to the illness experience is highlighted by the pathographies. Their role in recognising abnormality, providing support after diagnosis, and negotiating with the medical profession for the best possible care has frequently been marginalised. While the dominance of medical relationships has been confirmed by the pathographies, the professional, humane, and beneficial image officially projected has been refuted. The majority of sufferers communicated negative experiences, especially in relation to institutional treatment. Perceived as punitive and detrimental, the institution is primarily view as being a place where abnormality is inhumanely confined not treated. The fundamental role of the community in shaping responses to mental illness has been illustrated by the expressed attitudes and reactions of family and friends, and can be observed in sufferers' accounts of psychiatric practice. Most especially, the stigma associated with mental illness is highlighted by pathographers as being a barrier to full recovery. For while they may get better mentally, they often struggle to recover their lost position in the social fabric of life. Importantly, these relationships do not automatically result in a specific experience that is either predominantly positive or negative. Within each group there are individuals who help, and hinder, the sufferer's recovery. This chapter has reflected on what pathographies can tell us about the illness experience by examining the illness relationships detailed. Conversely, in the next chapter I look at what sufferers' narratives omit, considering what meaning, if any, can be inferred from the silence which remains.

Chapter Three

Unspoken Madness: Silence and Anti-Silence

In silence we recognise that which cannot be verbally expressed, either because it eludes accurate description, or because its communication is too socially or psychologically dangerous. Silences are important because they edify us to the fact that it is impossible to know everything; at any given point our perspective is limited by the availability of evidence and by our skill in interpreting that raw material. Additionally, the information may be limited as to what it can tell. This is especially the case with pathographies; Anne Hunsaker Hawkins notes that pathographies are ‘invaluable in teaching medical students, less perhaps to understand the experience of illness – for no written account can replicate what it is like to be ill – than to grasp the importance of the assumptions, attitudes, and myths that patients bring to the medical encounter’.¹⁴⁰ This is especially relevant for the pathographies of mental illness sufferers, where there is much to be silenced and where accurate representation is often elusive.

This chapter looks at the occurrence and significance of silence in the pathographies examined in this thesis. Beginning with a discussion of the silences which arise in relation to family and friends, this first section considers what meaning can be elicited from silence. Given that the previous chapter noted the importance of the role which family and friends play in illness experiences, silences pertaining to these figures are worthy of further scrutiny. Whether the result of painful experiences, or narrative construction, these silences highlight the complexity of kinship and friendship relationships. Following this, the chapter considers silences relating to the medical profession. It discusses silences of trauma which are the result of abuse by medical staff or as a

¹⁴⁰ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography* (West Lafayette, Ind.: Purdue University Press, 1999), p. xi.

result of a failure to provide a safe environment where patients were unable to traumatise each other. It also examines the underlying culture of silence which pathographers see as characterising institutional treatment.

The third section of this chapter looks at 'anti-silences' – where the author deliberately expounds on a subject which is highly emotive, traumatic, or shocking, usually in a very explicit way, either because they want to be deliberately provocative, assert control, or because they are using it as a form of therapy; what might colloquially be thought of as exorcising one's demons. It considers what such responses reveal about illness experiences and their historical context. The final section considers silences which arise because of insufficient means for accurate expression. Attempts to overcome narrative silences by adopting various narrative strategies are also considered. Silences of narrative are particularly pertinent to discussions of pathography because they highlight the limitations of the written form. Overall this chapter looks at the nature of the silences arise out of mental illness experiences, and considers where, why and how silences occur, by looking at a select group of pathographies, considering what is concealed, or absent. Despite pathography being fundamentally about the breaking of silence there are certain details which remain unvoiced, either by design or because they fall outside the scope of the narrative, or the pathographer's comprehension.

Family and Friends

The previous chapter examined the nature of illness relationships, asserting the importance of the role that family and friends play in experiences of mental illness; not just in caring for the patient, but in recognising symptoms of disorder and seeking treatment, or more negatively, in refusing to acknowledge the illness and being part of its cause. Given the significance of family and friends, any associated silence is of considerable consequence and indicates the complexities

which attend these most intimate of illness relationships. This section examines these silences, unpacking, as far as possible, their meaning, while considering why it is that they occur.

Suzanne Tocher's pathography is notable because of an almost complete silence relating to her siblings, and to a lesser extent, her mother. Despite informing us at the beginning of her narrative of their existence, Tocher does not directly mention her brother or two sisters again; only indirectly referring to them when using an all inclusive 'we'. It is unknown how they reacted to her illness, what role they played, if any, in that illness experience, or whether their shared childhood trauma influenced them in similar ways. Multiple possibilities present themselves to explain this silence, including that it is a reflection of the reality of their involvement in the illness experience, that it reflects painful memories regarding their involvement, or that she wishes to protect their identity; this later argument being supported by the exclusion of all identifiable names. However, without further evidence much of this would belong to the realm of speculation.

In contrast to the largely silent role of Tocher's mother and siblings, her father occupies a central position in the narrative, the legacy of his own re-enacted trauma shadowing Tocher beyond her initial upbringing and providing explanation for her illness. His dominance provides a vital clue to the silence of other family member in its suggestion that their exclusion is narrative related. Her mother and siblings do not have a key role in the narrative which Tocher tells because they are not perceived to have been responsible for her illness. Primarily focused on making sense of that illness by coming to terms with what has happened and accepting it, the narrative necessarily discusses the influence of her father's psychological abuse. Tocher's example illustrates an important point about the knowledge which pathographies communicate. As noted in the first chapter, the pathography is a constructed representation which conforms to the sufferer's design. Therefore, silences, not just in

Tocher's narrative but in all of the narratives under investigation, may be the result of construction, not deliberate suppression.

Graham Bishop's pathography is also notable for its silences relating to family. Brief mentions of his sons and wife are made at various points in the narrative, but their role is largely subservient to that of the medical profession. While Bishop explains his wife's absence early in the account, informing the reader that after 26 years of marriage they 'fell apart', he does not fully elaborate on the role his illness played in this separation, stating that 'the intricacies of it [the break up], are private to the two of us and I have not intention of revealing them'.¹⁴¹ Bishop's defiant acknowledgement of this silence is significant for two reasons. The first being that it highlights the fact that certain information will be suppressed for reasons of privacy, and the second, that it once again emphasises the importance of narrative design. Like the silence about family in Suzanne Tocher's narrative, Bishop's wife's role remains largely silent because the narrative is focused on the treatment he endures under the care of the medical profession. This argument is supported by hints of Joan's continuing involvement in Bishop's life. He comments, regarding a threatened transferral to an institution fifty miles away, that he 'drew considerable comfort from the fact that Joan, even though we were by now estranged, would never have allowed it'.¹⁴²

While the argument about silence resulting from narrative selection equally applies to the limited involvement of his sons, Bishop provides an alternative reason for the silence of both sons and a further explanation for the silence of one son. The first of these is provided when he details the ramifications of changes to his leave conditions. Bishop explains that his leave became subject to having a family member present, something which was not possible, 'as one of my sons had a full-time job and the other lived 30km away'.¹⁴³ Their involvement

¹⁴¹ Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Steele Roberts, 2000), p. 24.

¹⁴² Bishop, p. 44.

¹⁴³ Bishop, p. 86.

in his illness experience is, therefore, limited by their own life commitments and circumstances. The second explanation for the silence of one son can be identified in inclusion of another silence. Early in his narrative Bishop hints at the sexual abuse of one of his sons by a wealthy Dunedin professional:

A Dunedin accountant and stockbroker was eventually convicted of sexual abuse. The total number of his young victims may have exceeded a hundred. One was his own son, one was ours. Ours was 11 at the time, he was 21 when we found out – ten years of anguish, of knowing something was wrong but never for a moment suspecting what.¹⁴⁴

The fact that this incident appears in Bishop's narrative suggests something of its significance. Unable to cope with his own trauma, Bishop's son distances himself from the family and withdraws from family life; this distance explaining his silence through lack of actual involvement.

One final comment relates to Bishop's own childhood and a family silence centred on his own father, who supposedly committed suicide by drowning himself at sea. His clothes were found but his body never recovered. Reasons for the suicide ranged from bad debt to homosexuality; the latter being in Bishop's opinion more likely. Aside from growing up without a father, Bishop makes the somewhat cryptic comment 'but he left me with a legacy to which I will return'; cryptic because he fails to elaborate overtly at any point in the narrative which follows. Could this legacy be his mental illness and own suicide attempts – an inherited imbalance? Or is he hinting at the suicide as something which might have contributed to his illness, in a similar way to Suzanne Tocher's father being a contributing factor in her illness? If so, it highlights the significance of families in occurrences of mental illness.

The absence of family may also be explained by deliberate exclusion – the sufferer keeping their family at arm's length, where their illness is concerned, either because they fear the reaction that revelations of

¹⁴⁴ Bishop, p. 26.

mental disorder will evoke, especially rejection, or because they feel uncomfortable discussing it with them. For example, in the following excerpt Kathryn McNeil details not wishing to discuss her illness with her parents:

I don't talk to my parents about it very much because although I think they probably understand it quite well, I just don't feel comfortable talking to them about it. I don't really talk to family about it at all. I mean, they all ask but I just don't really care to share it with them. I think family are a bit close sometimes for those sort of things. And if you feel a certain way, maybe your parents feel that it's their fault even if it isn't.¹⁴⁵

In explaining that she feels uncomfortable discussing her illness with family because they consider themselves responsible for it, McNeil alludes to the tension which mental illness can create between sufferer and family. Silence may be the result of differing responses to mental illness, with one party wishing to discuss it and the other preferring not to. Similarly, Sarah Pokoati also describes not wishing her family to know about her illness because she feels embarrassed by her condition and fears the associated stigma and consequent rejection of being mentally ill. Interestingly, the revelation of her suffering leads to the discovery of a family history of mental illness which had been kept silent. The suppression of this history, apparently motivated by shame and fear of social rejection because of connection, highlights how mental illness can become a perpetuated silence.

The silence of friends from the pathographies poses similar questions to that of family, and many of the explanations remain the same. Yet, the dynamics of friendship are different from those of family. Friendships tend to be more transient than family relationships, being dictated by numerous external factors, including social opinion. Most obviously friends involve choice, as opposed to family who are largely predetermined, and they reflect, much more overtly, social and cultural

¹⁴⁵ *A Gift of Stories*, gathered, edited and compiled by Julie Leibrich (Dunedin: Otago University Press, 1999), p. 22.

constructions of mental illness. Both Graham Bishop, and more directly, Graham Johnson, explain the absence of friends as an inability to cope with the ramifications of their illness. Bishop describes how the simultaneous arrival of multiple psychiatrists with the police, and 'a friend with whom I was keenly anticipating going to dinner' resulted in the end of that friendship.¹⁴⁶ On 'seeing the brouhaha, along with the constabulary, she decided another night might be better. I never saw her again'.¹⁴⁷ It appears that the friend decided not to pursue the relationship as a direct result of this incident. Perhaps the police presence caused her to surmise that Bishop was violent or a threat in some way not previously conceived. It is, however, also plausible that this incident made her aware of his illness and this awareness caused her to terminate the friendship.

Friendships, as noted in the previous chapter may also be broken because of the manifestations of the sufferer's illness, as is the case with Graham Johnson (page 61), whose narrative not only highlights the cost of illness in terms of friendships, it also illustrates the motivation this loss can provide to remain well. His comment that 'The memory of it is too painful'¹⁴⁸ also alludes to a silence regarding the nature of Johnson's behaviour. What kind of behaviour could result in a loss of friends which left them with memories so painful they could not forgive? Johnson does not further elucidate on this matter, perhaps because he is ashamed of his behaviour, or because the memory of it is also too painful for him. Most importantly this silence informs us of the wider shared trauma of illness, felt not just by the sufferer, but by their wider support network.

Sarah Pokoati also identifies her altered behaviour as resulting in a loss of friends. However, for Pokoati, her own desire to be left alone results in the silence of friendships. She explains: 'I lost a lot of my friends when I became sick. I just excluded myself and I didn't want to be around

¹⁴⁶ Bishop, p. 80.

¹⁴⁷ Bishop, p. 80.

¹⁴⁸ *A Gift of Stories*, p. 42.

them'.¹⁴⁹ This withdrawal is not only a part of the disorder (schizophrenia often resulting in a person becoming withdrawn into their own private, psychological world), it also represents a desire to avoid the social stigma that attends mental illness. Pokoati's excerpt illustrates how sufferers can make friends silent through their own withdrawal from the relationship.

One final observation on the silence of friends comes from Graham Bishop's narrative. Interestingly, he suggests a more sinister, deliberate, and controlling reason on the part of psychiatric staff for the silence of friends. Describing a friend's visit to Wakari Hospital he notes: she 'was told that I was "too disturbed". She persisted to find that I was sitting outside in the sun and was calm and as normal as one could be in the circumstances'.¹⁵⁰ This incident illustrates how friends may remain silent through circumstances beyond the sufferer's control. Perhaps most importantly, this incident alerts us to the culture of silence which underlies mental health care, a culture which operates in silence but whose effects are very real.

Medical Silences

In addition to the silences of family and friends there are also those within the narratives examined in this thesis which relate to medicine, including silences of culture, abuse, and less frequently, the almost entire absence of such aspects. Given the dominant role of the institution in experiences of mental illness it is unsurprising that it should feature most prominently in the discussion which follows. 'Arguably', Diana Gittins observes, 'the whole institution, at least until 1960, was about silence. Madness itself was a silence and something to be silenced'.¹⁵¹ This section considers specific silences, which suggest the suppression of painful memories, and also the theme of silence as it pertains to the culture underpinning mental health.

¹⁴⁹ *A Gift of Stories*, p. 28.

¹⁵⁰ Bishop, p. 85.

¹⁵¹ Diana Gittins, 'Silences: The case of a Psychiatric Hospital', in *Narrative and Genre*, edited by Mary Chamberlain and Paul Thompson (London; New York: Routledge, 1998), p. 49.

In detailing their institutional experiences the majority of pathographers emotively recount horror stories of the dehumanising, disempowering and punitive environment characteristic of psychiatric hospitals. A few allude to more disturbing abuses without fully describing their occurrence. These hints alert us to the presence of silences which suppress psychologically dangerous memories of traumatising events. 'Fear, pain, [and] shame', Gittins notes, 'are undoubtedly major forces in the repression of memory'.¹⁵²

In particular a reoccurring theme, especially in the narratives of female patients is that of sexual violation, either by staff and fellow patients.¹⁵³ Susanne Tocher cryptically notes:



The nurse is in training.
He is meant to protect me,
but he takes from me instead –
his lies are uniform blue,
masquerading as the truth.
He opens wide an untouched door,
then turns and walks away.¹⁵⁴

While Tocher does not directly state that she has been raped by a male nurse, she alludes to the fact in the second to last line of this segment: 'He opens wide an untouched door', which is suggestive of lost virginity. The details of this event remain unspecific, perhaps because Tocher does not want to dwell on it, or because she cannot – the memory being too painful. This later argument is supported by the isolated position of the segment in the narrative. Segregated from the rest of the account by a line of barbed wire, this division mirror the sharpness of the pain and trauma still associated with the event. These silences are greatly significant because they edify us to the legacy of pain which many

¹⁵² Gittins, 'Silences', p. 47.

¹⁵³ For narratives detailing sexual abuse by patients see Susie Crooks' account in *A Gift of Stories*, p. 11, and Sarah's narrative in *Four Māori Korero about their Experience of Mental Illness* (Wellington: Mental Health Commission, 2000), p.26.

¹⁵⁴ Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington: Philip Garside, 2001), p. 25.

patients retain long after the initial trauma has occurred. Memory keeps that trauma alive, and though patients might manage most of the time to suppress remembrance of abuse, malicious deception, or stigma, inevitably these re-surface, usually unconsciously, a key times, such as in pathographies. Most importantly, these medical, trauma-related, silences alert us to the complexity of the mental illness experience and attest to the strength needed to become well again, especially when the system designated to heal only deepens the anguish. As Susie Crooks attests: 'Sure, I am permanently damaged, not by the illness but by the trauma of the treatment I received. I still haven't got over it'.¹⁵⁵

Tocher's silence is not only personal, but points to an underlying, largely silent, culture of abuse in institutions. Contrary to the projected image of professionalism and humane treatment it is made apparent by pathographers that institutions are sites which hinder recovery rather than foster it. Describing a return visit to Cherry Farm Hospital, former patient Natasha recounts the following incident: 'An intellectually handicapped man tried to ask the male nurse something and the nurse jumped on him and beat him up. When the other visitor and I wrote and complained, the incident was denied'.¹⁵⁶ The culture of institutional denial so obviously evoked in this brief segment is a once legitimate by and a reflection of, a wider social silence relating to mental illness. Isolating and silencing, the institution is the site deemed appropriated for the suppression of society's fears of abnormality and madness.

The most pervasive of the silences related to the culture of the psychiatric system is the suppression of information; either patients not being informed of their treatment, or being unable to ask questions. Kathryn Miller, in the excerpt which follows, details her uninformed consumption of medication:

¹⁵⁵ *A Gift of Stories*, p. 12.

¹⁵⁶ *Shadows and Silence*, narratives gathered, edited and compiled by Clare Goodwin (Wellington: Steele Roberts, 2004), p. 16.

Every meal time she was given a handful of coloured capsules by a nurse. The nurses were usually young and rather sweet and trying hard to be responsible. “You must take the medication the doctor has ordered for you.”

No one ever told Kathryn what the capsules were, what they were for, or why she was given them, or who the doctor was.

No one ever discussed the E.C.T. with her. What it was for, and why and how, and if there are any after-effects.¹⁵⁷

The silence Miller faces regarding her treatment is a reflection of the power of the medical profession and the disempowerment of the patient. The system maintains control by silencing knowledge, the result of which is the silencing of objection within the system, but more importantly outside. For, in a society which measure truth on verifiable factual information, to be without the necessary knowledge that supplies proof for ones claims, is to have diminished authority. Thus not only are patients silenced by social perceptions of illness, they are also silenced by a culture which gains its dominant status by retaining a monopoly on knowledge.

Its success in this is largely founded on fear, which keeps the sufferer silent and which silences their questions. On being told that she is homosexual by her psychiatrist, ‘the Doctor’, Miller spends the time between sessions agonizing over the revelation. However, ‘he never said the word “homosexual” again. Miller was too terrified to ask him, and so she was left in the limbo of Dante’s inferno, on her own, and alone’.¹⁵⁸ On many similar occasions Miller feels unable to ask questions – she does not want to upset the doctor for fear that he may tell her she ‘has to go’, leaving her alone with her misery. This policy of silence operates on multiple levels, silencing not just the information but the individual’s pursuit of it. Such silencing begins the moment the sufferer first comes in contact with the system. By taking advantage of the impaired reason of the sufferer it provides the required information

¹⁵⁷ Kathryn Miller, *Kathryn* (Rotorua: Tancred Press, 1984), p. 173.

¹⁵⁸ Miller, *Kathryn*, p. 84.

but is circumspect about its explanation, conscious that in most instances, as with Miller the sufferer is incapable of being fully informed:

As Kathryn sat, dazed, in the reception room of the psychiatric hospital, a white-coated doctor put a form in front of her worried and confused eyes for the to sign. Something about “treatment”.

She supposed that she was there for treatment, anyway, but she was too tired and too exhausted to read the closely printed sheet, there were so many words in fine, black print. Kathryn signed, not knowing what she was signing.¹⁵⁹

Too ill and, what is more, too desperate to know or care what she is agreeing to, Miller soon becomes aware of the folly of supposition when she discovers she is not simply able to leave hospital because *she* feels better. Having consented to treatment she has inadvertently signed away her autonomy.

Given the dominance of scientific medical enterprise in the classification and treatment of mental illness, the silence of the medical perspective in pathographies under examination is significant and demands further consideration. While admittedly none of the pathographies entirely avoid touching on medical matters, there is one for whom such aspects are secondary to a more personal experience which focuses on the thought and the felt. Suzanne Tocher’s pathography only briefly mentions her time spent in a psychiatric hospital, seemingly primarily for contextual reasons. The main focus of the narrative lies with her confused thoughts and feelings – the mental state of her illness. Many of the comments made about her hospital experiences relate to patients, not staff. However, as noted above, Tocher’s account does include a silence related to a male staff member, so perhaps this silence is a clue to the largely absent medical element – the trauma of her experience leading her to blot out much of this part of her story because it is too psychologically dangerous to re-live. It is also possible, that the absence is the result of narrative intention – the account given being the one which Tocher wishes to tell; one which does not involve medical

¹⁵⁹ Miller, *Kathryn*, p. 170.

aspects, other than in passing explanation of her 'journey to mental health'.

One final explanation for this silence of medical perspective draws on the concepts of power and disempowerment. Tocher may avoid medical aspects as a way of re-empowering herself. As the dominant perspective on mental health, medical narratives disempower the sufferer and their alternative viewpoints. The nature of treatment also disempowers patients by placing authority over illness with a system which frequently pursues disorder in isolation from the sufferer – patients feel helpless, much as Graham Bishop expresses, having little say over their own body. In conscious exclusion Tocher re-empowers herself by refusing the disempowering influence of medicine a dominant place in her narrative and by using, as noted above, its official account of her care in the form of medical notes to illustrate the unenlightened mindset of the profession. In these respects Tocher's narrative is more passive in its resistance than that of some of the pathographers who express their anger and indignation more actively, as we shall observe in the next section, by employing anti-silence.

Anti-Silence

'Far from being "silent and censored"', asserts Kerry Davies, 'patients have always relied on different narrative forms to have some sort of say'.¹⁶⁰ Within a conventional, mainly written, narrative structure, pathographers make use of anti-silence to challenge the socially and medically imposed silence which suppresses their experiences. Anti-silences – the deliberate voicing of information that would usually remain silent – closely align with the purpose and nature of pathography, which seeks legitimate expression for socially and medically unacceptable narratives. However, what distinguishes anti-silence from pathography in general, is its expression. Anti-silences, being usually motivated by

¹⁶⁰ Kerry Davies, "Silent and Censored Travellers"? Patients' Narratives and Patients' voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, 14.2 (2001), p. 272.

pain, indignation, or anger, is deliberately provocative and unapologetically graphic; it makes no concessions to alternative viewpoints, justifying its position on the premise of 'just telling it like it was'.

Typically, anti-silences recount instances of sexual or physical abuse, deliberate psychological cruelty, especially by institutional staff, and reckless disregard for patient wellbeing. As noted in the previous chapter (pages 68-9), Denise's account provides an example of this type of narrative. Unsettling in its suggestion that mental hospitals, rather than being places to get well, are sites in which disorder is simply contained – shut away from public view, but not cured, Denise's account refuses to gloss over her experiences. Most disturbing is Denise's articulation of the fact; her awareness of the situation conveys comprehension and challenges social ideas about mental illness. It also queries the nature of treatment and its justification – it is not possible to maintain a semblance of comfort by reasoning that the sufferer is protected by ignorance. In this respect anti-silence is an account which society wishes to silence because it demands redress.

The boundaries of narrative acceptability are not static – we need only look to the publication dates of the pathographies to note how recently patient narratives have become acceptable. Prior to this time, dominant, socially-condoned medical narratives held sway over public knowledge and opinion. These narratives in turn aligned with public sentiment, telling the story of progress which society wished to hear – one which provided psychological comfort, via its suggestion that socially condoned, medical intervention was justified. Pathographies which criticize this narrative challenge social complicity leading to a discomfort of conscience. Indeed, it is interesting to note that the above anti-silences all relate to the medical system. Within the dynamic of anti-silence there appears to be a favouring of medical condemnation; less frequently family are the subject of such exposés. This is perhaps best

explained by the differing nature of the two relationships – the one professional, the other personal.

With the greater formality of the former comes fewer bonds of loyalty to compel silence. This is perhaps most noticeable in Graham Bishop's pathography, which in its focus on the shortcomings of the system of care he endured refuses to be silent, either in its imparting of knowledge, or in its emotive expression of the effect. Whilst the whole narrative, in accordance with the nature of pathography, breaks silence, it is through his poetry that he fashions the deliberately provocative anti-silences. For example, the excerpt below details what is tantamount to murder, certainly reckless endangerment and malpractice:

I made a friend in 10C, the only friend in a year at Wakari. Brian Wilson was only a few years older than me, an ex-naval radio operator. He had emphysema and had been in the system for years, and it was killing him with a cocktail of pills. He would joke they were always ready to give him a new one, but no-one ever stopped any of the old ones.... His dearest wish to get into some supported accommodation in Central Otago. But it wasn't to be.

Fourteen, fifteen, sixteen pills
How many more before it kills
Tinker tailor, sailor man.

It took 16 he died a few weeks later, when I was in 9B. No-one thought to tell me, and he had no other friends.¹⁶¹

The poem itself is deceptively simple in its childlike composition, and indeed mirrors the childhood English counting game, nursery rhyme, and fortune telling song "Tinker, Tailor". There is, however, nothing innocent or childlike in its message. This is perhaps what makes it so disturbingly emotive. In its conflation with childhood, the poem is also hinting at the treatment of patients as children, under a culture of suppression, conformity, punishment and control.

¹⁶¹ Bishop, p. 104.

Oral historian Alistair Thomson has developed the concept 'composure', which he asserts underlies interviewees' narratives. Narrators compose their account, firstly to align with social expectations, especially 'acceptability', and secondly, to allow the teller a sense of composure – usually achieved by fulfilling the first requirement.¹⁶² Equally applicable to written narratives, the idea of anti-silence being a form of composure appears incongruous with Thomson's specification of social acceptability. However, as Suzanne Tocher's narrative illustrates, anti-silence aligns with the second aspect of the definition, that of allowing self-composure. In allowing their anger, pain, frustration and disgust pathographers allow themselves to feel most composed by empowering their perception of the illness experience.

Tocher's pathography is most interesting for the way in which it subverts the authority of the medical profession by juxtaposing the medical notes which they kept on her while a patient against her own narrative to illustrate their deliberate ignorance and indifference:

Mental Hospital Medical Notes

30 July 1977

Admitted at noon from the Public Hospital where she has been taken after a small overdose. Distraught, demanding and crying often about how she should not be here. Says she does not want to stay. Dr feels that she must and it is hoped that it is not necessary to commit her. Given Largactil 50mgms at 1:30pm, which settled her a little.

I've lost a day. I've been unconscious for 24 hours. The Largactil makes me feel worse and more out of control and more terrified. I am screaming. The nurse shuts the door of the room that I'm lying in. There is no handle on the inside.

14 August 1977

Made to do her own washing today and activated. A little more spontaneity.

I cannot make any connections between myself and the clothes and the point of the task.

I am stuck in a lift with the light off and will be there forever. So there is no point in

¹⁶² Alistair Thomson, *Anzac Memories: Living with the Legend* (Melbourne: Oxford University Press, 1994), pp. 8-11.

getting washed or washing my clothes as there is nowhere to go – nowhere to be.

28 August 1977

Despondent, wailing (dry eyed) and listless. Using her old manipulative manoeuvres again.

I am beyond crying, wailing is the only way to express my despair.

1 November 1977

Quietly gaining confidence.

It feels too dangerous to show my feelings anymore.

25 February 1978

Everything fine. Discharged.

Each day I plot how I am going to kill myself.¹⁶³

The clinical notes quoted above are especially interesting given the emotive language used – ‘manipulative’; ‘immature and ridiculous’. This usage is noticeably at odds with the clinically precise, factually verifiable image which the profession publicly projects. Even without Tocher’s own perspective, we begin to understand the culture of power which, as pointed out above, silences and controls opposition and treatment. Tocher, somewhat ironically, uses their own word to highlight the failures of the system, which is especially noticeable in the last entry. In so doing she breaks the silence of medical culture and re-empowers herself. Anti-silence thus allows for composure because, in the expression of the unacceptable, sufferers release the suppressed pain, anger, and indignation and confusion that has hindered their recovery, allowing them to feel composed and, as noted above, empowered; and in this respect anti-silence conforms most closely to the therapeutic function of pathography. Nevertheless, it is not always possible to achieve composure, not just because social boundaries hamper desired expression, but, as we shall see in the next section, because sometimes narrative form and language is insufficient.

¹⁶³ Tocher, pp. 35-7.

Silence and Narrative

'No written account', Anne Hunsaker Hawkins notes, 'can replicate what it is like to be ill'.¹⁶⁴ Written from memory, pathographies are subjective accounts of reality which reflect the selective nature and limited accuracy of recollection. Kathryn Miller astutely highlights this distinction by remarking in her pathography that 'this is not the therapy Miller received but her memories of it'.¹⁶⁵ Not solely constrained by the silence of memory, patient narratives are additionally subject to a silence of expression which exists between experience and its articulation, the result of which is the unsaid. For sufferers of mental disorder, the task of chronicling their illness is further complicated by the need to find rational expression for experiences which are inherently irrational. Maintaining the accuracy and integrity of the experiences in the narrative is ultimately a practice of closest approximation; invariably, something gets lost in translation.

One approach to overcome this silence of accurate expression is to write a personally significant narrative, inclusive of apparently nonsensical material, regardless of whether it makes sense outside the individual's paradigm. Such an approach aligns with anti-psychiatric conceptions of the meaning of madness, which challenge the perception of unintelligible expression as senseless, instead suggesting, that meaning is dependent on, and supplied by, a person's social situation.¹⁶⁶ While it might appear to best fulfil the function of self-explanation, this approach has limitations. Most obviously, its meaning is highly individual and comprehension by a wider audience is imperfect at best. Unsurprisingly, none of the pathographies examined strictly conform to this approach.

However, by incorporating notes recorded at the time of the events described, Lorelei Burdett allows the disorder which they contain a place in her narrative. Instead of simply describing the abnormality of her

¹⁶⁴ Hawkins, p. xi.

¹⁶⁵ Kathryn Miller, *Injustice* (Rotorua, N.Z.: Tancred Press, 1987), p. 5.

¹⁶⁶ See David Pilgrim, 'Anti-psychiatry', in *Key Concepts in Mental Health* (London; Thousand Oaks, Ca; New Delhi: Sage, 2005), pp. 151-2.

thoughts Burdett exhibits the traces of her illness, an approach which reproduces, in part, the irregularity of her illness experience. 'The writing is confused,' Dr. Murray Cameron notes in his foreword to her narrative, 'and by design re echoes, and reverberates. For me it is like watching a home video / movie – it is real, it is immediate, it can return to the same scene, it can be blurry and out of focus ... this is what mental illness can feel like'.¹⁶⁷ In its confusion, Burdett's narrative closely aligns with her experience of bipolar illness, conveying, as the following excerpt does, the random and befuddled thoughts characteristic of her stream of consciousness style of narrative:

Saturday 27/4/01

Want to do everything at once – panic! Not sure of the day let alone the time.....

Headaches and backaches

Chill out

Windows cold

Ellwood (the cat) stalking. Girl. She doesn't say much!

Cat wants out but doors locked. Waiting, but I am assured he can get out the windows

Panadol

Sleeping Tablets

Fish basket of treasured thoughts

Kia a Whakatane

Kia Ora!¹⁶⁸

Largely consisting of non-sequiturs, and at times noticeably atypical in expression, Burdett's notes are primarily a collection of short key words

¹⁶⁷ Lorelei Burdett, *Mummy Why Did you Lie in the Middle of the Road?* (Christchurch: L. Burdett, 2008), p. 14.

¹⁶⁸ Burdett, p. 44.

or ideas. The connection of concepts such as ‘windows’ and ‘coldness’ illustrates Burdett’s unusual psychological state. Commonly windows are described from the perspective of their visual appearance, such as clear, misted, or even glinting, and while these adjectives might convey a sense of how the window feels, for example misted suggest coldness, it is not usual to directly describe how they feel to the touch. Additionally the word order is confused, being the reverse of convention, strengthening the sense of abnormality conveyed.

Also of interest are the final two lines which switch from English to Māori. These phrases stand in contrast to the predominantly English narrative, and to the notes collectively, which are also in English. Like the rest of the notes, the meaning of the phrases is unclear in relation to the previous thoughts. It is unknown whether Burdett is versed in the Māori language. However, these phrases, especially the second, are fairly common and it is possible that she could have picked them up without formally learning the language. However, their inclusion testifies further to Burdett’s abnormal psychological state, as does the rapid and disjointed direction of her thoughts generally. In creating a feeling of confusion in the reader’s mind the notes capture something of the essence of the manifestations of her mental illness. As Dr. Murray Cameron comments, ‘Burdett’s first hand account allows you to experience the disordered thought processes, the highs and lows of bipolar illness as Burdett lived her journey’.¹⁶⁹

This approach conveys the disorder of the illness, but does its disjointed confusion detract from its authority? Is it too confused? While Burdett interweaves excerpts from her notes into the narrative, they are not the entirety of the account. Burdett reflects on these examples, which are used to capture the essence of the experience, passing comment on their consequence in the narrative. ‘During these periods everything was in “hurry motion” and happenings had to be immediate’, she explains. ‘There was nothing rational and it was full steam ahead and to hell with

¹⁶⁹ Burdett, p. 14.

everybody else! The anger, pent up rage and super senses, were in full swing. Rationality did not stand a chance!¹⁷⁰ Burdett's narrative is lent authority by its reasoned explanations, which help elucidate not just the events described but also the strength of her claim to experience, so powerfully conveyed through the residues of her disordered mind.

An alternative approach is to communicate the narrative in a deliberately rational and objective way. Given society's equation of truth with fact and objectivity, bringing reason and order to bear on the disorder of illness affords pathographers' narratives greater respect. Graham Bishop's clearly articulated narrative, with its objective and rational approach, not only lends authority to what he says, but also testifies to his sanity, and the truthfulness of his claims. The following excerpt provides an excellent illustration of Bishop's rationalisation of his experiences and the length of his efforts to find concrete proof for his suspicions that the medication he has been given is not the Antabuse his psychiatrist claims it is:

Before it got too bad I knew there was one thing I had to do – it was the acid test, or rather the alcohol test. So I went downtown and brought some garlic, then as soon as the pubs opened I brought a glass of wine, and then a second. I knew I was taking a big risk, and if I was wrong and it was truly Antabuse it could well be all over, so I selected the old familiar 'Bowler', the hotel closest to the public hospital. I can't say I enjoyed the wine much, but, as expected..... nothing happened, absolutely NOTHING.¹⁷¹

Bishop's ability to rationally convey his experiences strengthens the veracity of his claims and challenges popular conceptions of mental illness. The above excerpt effectively illustrates Bishop's sanity by demonstrating his forethought of the consequences of his experiment – he chooses a pub with which he is familiar and which is closest to the hospital should anything go wrong and purchases garlic in order to help mask the smell of his experiment from staff back at Wakari. An educated

¹⁷⁰ Burdett, p. 38

¹⁷¹ Bishop, pp. 112.

geologist, Bishop is, no doubt, conscious of the authority afforded by his narrative style. But, in allowing rationality to dominate, does Bishop's narrative also lose sight of the disordered essence of the experience? His use of poetry, discussed in Chapter One, suggests at the very least that this approach is not fully able to convey the emotions which attend his illness experience.

A final observation relating to narrative silence is needed to consider the silence of effort that underlies the published narrative; as Graham Bishop attests, 'it has not been easy to write this account'.¹⁷² For many pathographers the account, though often part of their recovery, cannot be written until comprehension has returned and until they are strong enough to re-live their trauma. As Ben Benjamin notes in the preface to his pathography, 'I first considered the possibility of the book several years ago, but was unable to write it at the time because of my mental and physical state'.¹⁷³ Glimpses of the enormous effort, that has taken place to regain control and order, surface at various points in the pathographies. For example, the following excerpt from Benjamin's narrative describes his thoughts and actions at the manic point in his cycle of bipolar illness:

Suddenly I sensed danger. A nuclear holocaust was obliterating the Northern Hemisphere. I crawled into my sleeping-bag, covered my head and waiting [sic] until the acid rain stopped falling. I then crawled out of my fall-out shelter sleeping-bag, as though I were a baby emerging from a womb. I lay there like a baby, making baby noises. After a while I started to grow. I was five-years-old, making the noises a five-year-old makes. Then I was ten, and fifteen, and so on, until I grew into my adult state. After the holocaust New Zealand turned into the most beautiful paradise in the world. I imagined myself living in a mirror encased rotating pyramid on top of Rangitoto Island in Auckland's Waitemata Harbour. When the sun's rays hit the rotating pyramid, it sparkled and showered Auckland with ethereal light and provided the city with solar energy.¹⁷⁴

¹⁷² Bishop, p. 75.

¹⁷³ Ben Benjamin and Ian Dougherty, *Out of My Mind: Living with Manic Depression* (Auckland: Tandem Press, 1994), p. 9.

¹⁷⁴ Benjamin, pp. 50-1.

The confusion of Benjamin's thoughts as well as his inability to distinguish reality from delusion are illustrated by his rapid mental shifts between ages and the accompanying sound effects he makes. But what is most important is the effect the narrative has on the reader. We feel, as if we too have gone through this ordeal and it is necessary to take stock of our own sanity and to placate the sense of panic we feel when bombarded by rapid and unusual thoughts. It is in the shared confusion between reader and sufferer that we glimpse, through our own unease, the suffering that which all too often remains silent behind the mask of ordered expression demanded by effective communication.

This chapter has examined the occurrence and significance of silence in the pathographies under investigation in this thesis. The silences about family and friends in the texts contrast with the previous chapter's observations about the central role of family in sufferers' experiences of mental illness. Protection of privacy and narrative direction have presented themselves as the most likely explanations for this silence, although family tensions have been shown to be relevant in certain instances as testify to the complex negotiations which take place around mental illness. Medical silences have, unsurprisingly, highlighted the culture of silence which underlies institutional care and also the legacy of trauma which the patient retains long after their discharge; a disempowering legacy which patients sometimes suppress by excluding as far as possible all mention of medical endeavour from their account.

Alternatively, some patients choose to deliberately detail traumatic experiences breaking not only their own personal silence but also a social silence which suppresses expression of these frequently socially unacceptable occurrences. Anti-silences are primarily an expression of grievance, anger and pain. In allowing the sufferer a voice for their hurt they are congruous with the therapeutic plot which is characteristic of pathography. As noted regarding silences of family and friends and the medical profession, the absence of key figures may be the result of

deliberate narrative exclusion. Similarly, silence in general may also relate to narrative expression, being the result of insufficient means by which to accurately detail what has occurred. Sometimes, especially where the irrationality of mental illness is concerned, exact experience eludes communication. Above all, silences inform us of the boundaries of knowledge; it is impossible to know everything. Diana Gittins notes that, 'silence has long shadowed madness.... The tragedy is that so many silences can never be accessed'.¹⁷⁵ Perhaps, this realisation is the ultimate insight of mental illness, as even for sufferers, reason may remain silent.

¹⁷⁵ Gittins, p. 61.

Conclusion

Sufferers' experiences of mental illness are complex and destabilising. As witnesses to this, their pathographies reveal the physical, emotional and social ramifications of suffering. Pathographies are especially valuable for investigations of mental illness where the exact cause and manifestation of the illness remains uncertain. As Barbara Brookes notes, 'a broken mind is baffling in a way that a broken leg is not'.¹⁷⁶

Using fourteen New Zealand mental health pathographies published within the last thirty years, this thesis has demonstrated that published patient narratives are a valuable source of information for elucidating the patient's perspective. They inform not only about specific experiences, but also about that meaning to patients. Given ethical restraints and the fact that clinical records do not provide much of the patient's perspective, pathographies are one of the few sources which allow us a window onto the way sufferers perceive and experience mental illness. Unlike medical records, where the patient's voice is filtered through that of the psychiatrist or nursing staff, pathographies allow the patient's voice to be directly heard.

Pathographies communicate information not just through what they say but equally by the way in which they say it. Chapter One investigated the form of pathographies, including their motivation, their structure and their expression. Pathographers write because they wish to communicate to their selves and to a wider audience of fellow sufferers, medical professionals, and the community at large. Their purpose is most obviously identified in the themes which they evoke. Of these themes, three connected ideas occurred most frequently: institutionalisation, power and knowledge, and boundaries and identity. Institutionalisation was the foremost, and was used to critique the

¹⁷⁶ Barbara Brookes, 'Introduction' to *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, edited by Barbara Brookes and Jane Thomson (Dunedin: University of Otago Press, 2001), p. 9.

punitive, oppressive, inhumane, distorting, environment of the psychiatric institution. Institutionalisation significantly conveys ideas of powerlessness, dependency, loss, abuse, force, fear, secrecy, imprisonment, and most significantly control. In evoking the theme of institutionalisation pathographers primarily emphasise the detrimental effects of the system which is officially designed to make them better; instead of helping, they attest, it only hinders.

Underpinning ideas of institutionalisation and other medical experiences is the theme of power and knowledge. Michel Foucault highlights the fundamental link between power and knowledge asserting that power is not only based on knowledge, it also shapes and re-creates it to reflect specific agendas.¹⁷⁷ Pathographers emphasise an awareness of this link when they express their frustration at having information deliberately withheld from them and at being under constant surveillance the record of which officially and subjectively characterises and judges them.

Additionally, ideas of boundaries and identity are significant.

Pathographers express their illness experiences as a crossing of numerous boundaries, including that of inside and out, light and dark, life and death, normal and abnormal. The ramifications of crossing these boundaries are most important for selfhood or identity as their illness has come to characterise who they are.

Guided by purpose, the narrative aspects of the structure of pathographies are used to legitimise, shape, and make meaningful the illness experience. The most important of these aspects is the frame which pathographers use to direct their account. Two of the central narratives which the pathographers told were narratives of battle and narratives of loss. These narratives are revealing of patients' own perceptions of their illness and also of wider social and cultural understanding of illness. The mythologisation of illness is an area worthy of further investigation because myths are fundamental to the way we

¹⁷⁷ Michel Foucault, *The History of Sexuality: An Introduction*, vol. 1, trans. by Robert Hurley (London: Penguin, 1990).

perceive, react to and recount our experiences. Underlying narrative purpose and structure is expression, the words, devices and media used to convey what is meant. Emotive, figurative and technical language are all used by pathographers to effectively communicate their experiences. In particular, their evocation of animal and imprisonment imagery is extremely powerful. Congruous with the therapeutic function of pathography, their use of various media significantly testified to the inability of words to fully convey experience. I argue that collectively, the purpose, structure, and expression of the pathographies, are responsible for the communication of meaning and that their consideration is vital if we are to fully understand mental illness experiences.

An integral aspect of the illness experience which the pathographies elucidate is illness relationships. The focus of Chapter Two, illness relationships were shown to be multiple and complex. Reinforcing the observations of other historians, the centrality of family and friends was a key finding of the chapter. Family, in particular, were shown to be of central importance pre-diagnosis and also afterwards.¹⁷⁸ Their advocacy, support, endurance, and loyalty were all demonstrated as being central to the recovery process. The dominance of medical relationships was also confirmed, although rather than the benevolent image projected, pathographers mainly criticise the punitive culture of secrecy, dominance and excessive medication which they experienced. Community relationships were also identified as being of fundamental relevance not just to patient's perceptions of their own illness, but also to the perceptions of family and friends and the medical profession. In particular, stigma was emphasised as being of great importance in

¹⁷⁸ Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Australia and New Zealand, c. 1880-1910', and "'His Brain was Wrong, his Mind Astray": Families and the Language of Insanity in New South Wales, Queensland and New Zealand, 1880s-1910'; Jennifer Robertson, "'Unsettled, Excited and Quarrelsome": The Intersection of Violence, Families and Lunacy at the Auckland Asylum, 1890-1910'; Emma C. Spooner, 'Digging For the Families of the Mad: Locating the Family in the Auckland Asylum Archives'; Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860*; Mark Finnane, 'Asylums, Families and the State'.

patients' recovery as reconnection with their social existence was hampered by the tainted legacy which mental illness imprinted on their identity. The interaction of family, friends, the medical profession and community around the sufferer was also identified as being of significance. Whether cooperative or confrontational, each group were shown to interact not just with the sufferer but also with each other. In this they confirm Roy Porter's identification of medical events as being 'complex social rituals'.¹⁷⁹

Though pathographies offer us great insight, their silences remind us that, inevitably, there are certain things that remain undisclosed, either because they are too painful to describe, because they are forgotten or because they are perceived as unimportant. With Luisa Passerini's conception of silence in mind, Chapter Three considered the significance of silence in narratives of mental illness.¹⁸⁰ Although subconscious trauma is a significant explanation for deliberate exclusion, narrative design and constraints present themselves as the primary reasons for omission. Silences echo traumatic experiences, however, given popular institutional understandings, they were not as numerous as I had initially expected. Those that did exist were, unsurprisingly, mainly related to psychiatric hospitals, in particular sexual abuse of female patients by male staff or patients.

Many of the silences were absences; there was no hinting at experiences and events that had occurred without further explanation – certain factors simply did not feature. In such instances narrative design presented itself as the most likely explanation. Family and friends were either absent because they were literally not part of the events, they were outside the focus of the narrative, or the pathographer wished to protect them. Additionally silences could be explained by the constraints of the narrative; pathographers being unable to accurately express,

¹⁷⁹ Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), p 175.

¹⁸⁰ Luisa Passerini, 'Work Ideology and Consensus under Italian Fascism', *History Workshop Journal*, 8 (1979), p. 84.

using a written narrative, what they had experienced. Sometimes their experiences simply did not translate onto paper.

The limited identification of traumatic silences may be explained in part by the presence of what I am calling anti-silence. Congruous with the overall expressive function of pathography, although noticeably motivated by anger, and outrage, pathographers use anti-silences to deliberately give voice to traumatic and painful experiences. Instead of remaining silent they cathartically described abuses of their rights not just as patients, but as human beings and in doing so elucidated many of the silences which the medical profession in particular had perpetuated. Therefore, silences and anti-silence were shown, contrary to initial perceptions, to be greatly significant and informative.

This thesis has primarily focused on the medium of pathography considering what it can and can not tell us about mental illness experiences. Given the scope of the research there has not been space to investigate more specifically various aspects of mental illness, including ethnicity, class, gender, and age. Future investigations in these directions using pathographies would offer much needed insight not just into mental illness, but also into the limitations of pathography. Further consideration of race could elicit reasons for this dearth of broader cultural perspectives and offer valuable insights into differing perceptions and treatments of mental illness among non-European ethnic identities. The age of pathographers is also another key area of investigation which needs further research. Why are the majority of pathographers writing between their thirties and fifties? Does this relate to the coincidence of illness with wider social changes which legitimate personal narratives and view suffering as a topic for public discussion? Or does it suggest that pathographies are most therapeutically beneficial after the age of thirty? Regardless, it is apparent that much could be learnt from an examination of age.

Greater investigation into the significance of class and mental illness is an important avenue yet to be explored and while pathographies might only touch on a fairly narrow class of sufferers, consideration of why this is so is equally important, especially for what it can infer about those who do not write. A slight preponderance of female pathographers was another noticeable feature of the narratives worth greater consideration. Historians of the nineteenth century asylum have shown gender to be a key factor of distinction in experiences of mental illness, especially in determining committal and discharge.¹⁸¹ Similar investigations using these and other pathographies would elicit a deeper understanding not just of the differing treatment of males and females but also their different perceptions and characterisations of their illness. Finally, though this thesis has broadly investigated illness relationships, greater examination of the role of family, community, and the medical profession would be advantageous in further elucidating the influence of external forces on the illness experience. Historians have argued that the importance of family in the illness process has been overlooked and my brief investigation has confirmed this.¹⁸² Further examination of the role of the family in light of shifts in treatment, especially to a greater reliance on community care, would be useful.

The examination of sufferers' narratives undertaken in this thesis has highlighted the usefulness of pathographies for elucidating experiences of mental illness, most importantly late twentieth and twenty-first century perspectives. The pathographies examined are also valuable because

¹⁸¹ Barbara Brookes, 'Men and Madness in New Zealand, 1890-1916' and 'Women and Madness: A Case-study of the Seacliff Asylum, 1890-1920'; Bronwyn Labrum, 'A Woman's World in a Male Universe: Treatment and Rehabilitation at the Auckland Lunatic Asylum, 1870-1910', and 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', and 'The boundaries of Femininity: Madness and Gender in New Zealand, 1870-1910'.

¹⁸² Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Australia and New Zealand, c. 1880-1910', and "'His Brain was Wrong, his Mind Astray": Families and the Language of Insanity in New South Wales, Queensland and New Zealand, 1880s-1910'; Jennifer Robertson, "'Unsettled, Excited and Quarrelsome": The Intersection of Violence, Families and Lunacy at the Auckland Asylum, 1890-1910'; Emma C. Spooner, 'Digging For the Families of the Mad: Locating the Family in the Auckland Asylum Archives'; Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860*; Mark Finnane, 'Asylums, Families and the State'.

of what they reveal about perceptions of mental illness. Most importantly, pathographers are valuable because of the way they testify to the power of the narrative to heal. Their 'therapeutic plot'¹⁸³ is central to their importance because in writing their pathographies sufferers of mental illness make sense of what has occurred and heal the rift that exists between their 'self-in-illness' and 'self-in-life'.¹⁸⁴

¹⁸³ Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography* (West Lafayette, Ind.: Purdue University Press, 1999), p. 15.

¹⁸⁴ Hawkins, p. xviii.

Appendix 1

The Olive Tree Metaphor

The tough young olive tree
is able to withstand
very dry conditions.
Its leathery, spindle-shaped,
dark green leaves,
silvery white on the underside,
reduce water loss.

Long roots hold the tree
in place, absorbing water
and minerals from the soil.
Silently, secretly, life food
is channelled upwards.

p. 8.

The olive tree is growing.
Despite being accustomed to
long periods of low rainfall
it is capable of growing
to ten metres.

p. 13.

Winter chilling
of the olive tree
is needed to initiate flowering.

p. 20.

The olive tree is changing.

Small white flowers
appear in groups
under last year's leaves.

Soon one olive fruit
will be born
for every sixty flowers.
Then it will start its
six month journey
to maturity.

p. 28.

Fruit on the olive tree
is ready to be harvested.
A long toothed comb
strokes the foliage
and the olives are loosened.
They are washed, crushed
and pressed.

In order to release the oil
the entire olive
must be crushed.

p. 34.

The olive oil has antiseptic
healing and anti-clogging properties.
It opens the arteries.

p. 37.

The olive tree is pruned,
opening the tree
to light and airflow.

Dead and diseased wood
is cut off and burnt.

p. 42.

The olive tree is better for
the pruning and thinning.
Branches will grow back stronger
and next season's fruit
will be bigger and
more uniform in size.

p. 49.

The olive tree matures.

p. 53.

After 200 years
the trunk disappears
and the root systems
push out new shoots
to produce another tree.
And so the olive tree
keeps on bearing fruit.

p. 63.

Source: Suzanne Tocher, *Well Connected: Journey to Mental Health* (Wellington: Philip Garside, 2001), pp. 8-63.

APPENDIX 2

THE STRANGE LETTER 2 (A SONNET FOR A FRIEND)

Melt down the barrels they are hot enough 2 smoke
the Port Royal in my pocket in the old red Kauri tin
with one bent bullet
22 rounds, 22 deer
22 to go Shoot my friend
you missed the last chance
make this the last dance 4 2 of 3
the barren hind fell the second's
eyes were clouded
Katey – Jane walked small and tall
until the sun caught her standing on the hill
flashing her purple eyes
now I will hunt no more 4 you except 4 you
Unit 1 plus 1 equals 3 not 2

Source: Graham Bishop, *Poles Apart: A Touch of Madness* (Wellington: Roger Steele, 2000), p. 110.

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