Chapter 1: Introduction

> The single most harmful aspect of psychiatry is its failure to face up to and engage with personal suffering, stories of tragedy, loss, abuse and oppression.
>
> (Thomas and Bracken, 2008:49)

Background

In November 1987 I walked through the doors of my first psychiatric ward. I was twenty years old and two months into my training as a Registered Mental Nurse (RMN). The ward was a single story building set in the grounds of a large Victorian asylum. I felt confident and proud to be part of such an institution. Perhaps typical of the naivety of youth, I held high ideals of my ability to help distressed people. Within days, confidence was replaced by questions, ideals replaced by a sense of powerlessness. I can recall what happened quite clearly. I was dispatched to the patients' lounge to 'interact'. This interaction consisted of me sitting for two hours listening to a man telling me about the subterranean soap factory run by the KGB that lay beneath the whole of Leeds. I had no skills to engage with this dialogue. Drummed into me during my two month introductory course was that on no account did we collude with, reinforce or engage with delusions and hallucinations. Distraction and diversionary tactics were the order of the day. This patient was not to be diverted however, so I sat there in silence listening to his story. Later, in the ward round when patients were ushered into a room of psychiatrists, nurses, social workers and occupational therapists, I dared to suggest that maybe the man's delusions held some intrinsic meaning. There was much sighing and laughter and, afterwards, I was taken aside by my mentor and advised not to challenge, but to sit quietly and observe. "No one likes a clever clogs",

she said. However, I continued to challenge and question both as a student nurse and a qualified nurse. I was never the most popular person amongst some quarters, but the patients seemed to like me and that was what mattered.

It was these early experiences as a psychiatric nurse working in the old asylum that prompted a long-standing interest in how people designated 'mad' or 'mentally ill' understand their experiences. What is the meaning of this experience for the person? By what means do they understand their experiences? How do they vocalise them? To what extent do culturally dominant explanations infringe on their understandings? How do people reconcile alternative and competing explanations? How did people understand their experiences pre-psychiatry? What cultural explanations did they draw upon? How does illness and understanding relate to recovery both now and in the past? One way of finding out this information is to look at people's stories or narratives about their experiences. To do this, this study is pluralistic in approach, drawing on multiple disciplines; social constructionism, sociology, history, as well as cultural and literary theories. This interdisciplinary approach whilst difficult to negotiate, provides the hermeneutic, contextualist basis pivotal to this research.

There is a large amount of research that suggests the importance of the narrative structure for those experiencing serious and/or chronic illness (Bury, 1982; Faircloth et al., 2004; Carricaburu and Peirret, 1995; Charmaz, 1991; Frank, 1995; Kleinman, 1988; Williams, 2004). This research indicates the use of narrative for reintegrating the illness experience and the self into the life story. However, the majority of this research has focused on physical illness, with only a handful of studies looking at narratives of 'mental illness' (see Adame and Hornstein, 2006; Barker, Lavender and Morant, 2001;

Crossley and Crossley, 2001). There are several historical and cultural reasons underlying the dearth of narrative work in madness. Historically, it is argued that madness has been both physically and culturally silenced. Foucault in his recently re-translated work *History of Madness* talks of the Great Confinement of Western Europe, where the mad replaced the lepers, being physically separated and shut away from the rest of society. This was more than the physical excision of the mad, it was a cultural means of silencing, where the voice of unreason was subjugated by the voice of reason. The asylum, the emergent psychiatric profession and their knowledge and technologies, resulted in the production of power that silenced the stories of the mad. The history of the voice of madness is not a historical void however. There are over six hundred first hand accounts of madness dating from the 1400's.[1] Why then is the voice of the mad so conspicuously absent in theoretical literature? First, there are a far greater and more accessible number of professional accounts and historical documentation of madness and its relationship to medicine. Second, in many contexts, the narrative of medicine is so prevailing that it invalidates narratives of madness. As Barrett revealed in his anthropological study of a schizophrenia facility, patients' narratives are only included as part of the diagnostic construction (Barrett, 1996). When a person's description of their experiences is constructed as illness, the narrative *becomes* the illness and the subjective perspective is invalidated (Hydén, 1997; Barker et al, 2001). For example, narratives of schizophrenia are treated as symptoms of the "illness", thus there is no truth in them, as such people "lack insight". The primary aim of my research therefore is to give space to these voices, validating their experiences as realities reflecting cultural, social and historical meanings. A second conspicuously absent feature of research on all illness narratives is that there are virtually no studies on how the

[1] See the bibliography of first hand narratives of madness compiled by Professor Gail Hornstein at

narrative shifts in relation to the social and historical context. One exception to this is the comparative study of anthologies of first hand accounts of madness from 1957 and 1996 (Crossley and Crossley, 2001). This intriguing paper demonstrates the shift from the individual, private voice, to the collective, public voice, relating this to deinstitutionalisation and the rise of the mental health movement, and the construction of the patient as a political consumer of health care. The second aim of my study is to extend this historical analysis further, analysing accounts from before and after the emergence of psychiatry using two sources: *The Book of Margery Kempe* (Staley, 2001) which is the first acknowledged autobiography written in the English language and, therefore, the first known firsthand account of madness; and *Two Accounts of a Journey Through Madness*, which details Mary Barnes' experiences of madness in the 1960s (Barnes and Berke, 2001).

Definitions

The decision to use particular terms in this research, in particular madness, schizophrenia and recovery, has been arrived at with great difficulty and needs some form of explanation. To take them in turn, madness is used throughout this thesis in preference to mental illness or mental disorder. The World Health Organisation (WHO) defines mental disorders as:

> a broad range of problems, with different symptoms. However, they are generally characterized by some combination of *abnormal thoughts, emotions, behaviour and relationships with others.* (WHO, 2007: emphasis added)

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http://www.mtholyoke.edu/acad/assets/Academics/Hornstein_Bibliography.pdf

Mental disorder is therefore set against what are considered to be normal behaviours, relationships and so on. Both this term and the term mental illness contain the underlying assumption that something is lacking or deficient when compared to the norm that is 'mental health', thus constructing a binary opposition between health and illness, order and disorder, which Foucault argues historically emerges from the discourse of reason about unreason that began in the seventeenth century (Foucault, 2006a). Thus the constructs 'mental illness' and 'mental health' present experience as a dichotomy: one is either in one state or the other. Derrida argues that word meaning is dependent on both the presence and the absence; in other words, illness or disorder could not exist without health or order (Derrida, 1981 in Gergen, 1999). Such binaries are not an innocuous relation but imbued with power, with presence being valued at the expense of absence; for example, rational over emotional, white over black, male over female, order over disorder, health over illness. Thus, the less powerful term in the binary is seen to be lacking, existing to show what it is *not* and functioning as a supportive mechanism for what the more powerful term *is* (Seabrook and Green, 2004).[2] Gergen highlights how dominant groups in society have laid claim to the privileged positions in binaries, such as the way in which medicine is associated with rationality, the body, sanity and order. By associating itself with the privileged constructs in binaries (rationality, the body, sanity, order, object) the professional group also lays claim to power, viewing others (the patient) as the opposite of the binary (emotional, mind, madness, disorder, subject). Fundamentally therefore, the terms

[2] However, in some binaries, the privileged term is in fact the negative part of the construct. For example, health and sanity are, in effect, the unexperienced; what does it mean to be healthy or sane, to be free from physical or psychological pain? These terms are defined by the absence of pain, by their opposing construct (illness and insanity). We frequently hear people remark "I never knew what good health was until my back went/my angina started/I started to get breathless". A chronic pain sufferer quoted in Arthur Frank's book *The Wounded Storyteller* encapsulates this thus, "I'm convinced only sick people know what health is. And they know it by its very loss" (Garro, 1992 in Frank, 1995: 141).

mental illness and mental disorder emerge from the province of psychiatry and medicine, and, whilst they may be appropriated by some in distress, they are rejected as labels by increasing numbers of individuals. Moreover, as Sedgewick argues:

> To say that somebody is mentally ill, or to announce oneself as mentally ill, is to attach complex social meanings to acts and behaviours that in other societies, or in different contingencies within our own society, would be interpreted in the light of quite different concepts. (Sedgewick, 1982: 25)

Here, Sedgewick draws our attention towards the fluidity and complexity of meanings within the term mental illness, meanings which are socially, historically, culturally and politically contingent. However, to dispense with the terms mental illness and mental disorder is not to deny the experience of those distressed, as Hodgkin clearly states:

> To discount the force of such experiences in the name of cultural relativity seems a failure of understanding. Madness, after all, is experienced as subjective as well as social. (Hodgkin, 2007: 4)

So whilst I argue that 'mental illness' is a trope constructed to serve the purposes of psychiatry and other institutions (e.g. pharmaceutical industry), the experience underlying such terminology is clearly not constructed. There are people who describe a subjective world filled with threat and danger, a dislocation from the perceived 'real' world, the intrusion of thoughts and voices seemingly beyond their control, a world suffused with significance and meaning incomprehensible to other people. My preferred term to describe such experiences is madness. Madness has been identified

across histories and cultures and, as Roy Porter observed, mad people were not so much invented by psychiatry, so much as classified by it (Porter, 1987). As I shall outline in the following chapter *History of Madness and Psychiatry*, the historical provenance of madness can be traced back to Ancient Greece (Socrates was a reputed voice hearer) and beyond. So what modernist psychiatry perceives as symptoms of specific syndromes, have been interpreted, and indeed continue to be interpreted, in different ways through different times and spaces. Visual and auditory hallucinations, social withdrawal, self neglect and delusions of grandeur, for example, become visions, voice hearing, solitude, fasting and the belief that one has been chosen for a specific task by a higher power. These shifting meanings and their association with different sets of beliefs are important for the definition of madness in this research. In medieval times such experiences were often associated with religious devotion and in some cultures, such as Shamanism and Spiritualism, they continue to be so, highlighting the boundary between madness and mysticism. However, it is important to note that one of the myths attributed to cultures such as Shamanism, Spiritualism and to medieval Europe, is that all unusual experiences (unusual to the modern day, secular West that is), are interpreted within a spiritual or religious paradigm. As I shall outline in my analysis of the medieval woman Margery Kempe, this is not the case. Clear cultural delineation is made between madness and the spiritual experience. Tobert, for example, notes that in the culture of the Daur Mongols of Manchuria, "Daur Shamans were invited above all to cure mental illness and depression" (Humphrey, 1996 in Tobert, 2001: 42). For the Daur people there are different forms of madness that are distinctly different from spiritual possession.[3] Different states of consciousness are therefore interpreted

[3] *Koodoo* is someone struck by madness affected by the spirits following a tragic event. *Beleng* on the other hand has no connection with the spirits, being an uncontrollable affliction or mechanical reaction to a shock. *Bong* is a zombie-like state, where the sufferer appears to be without soul or volition (Tobert, 2001: 42).

differently by different cultures at different times. What is defined as mad or normal in one space and time takes on different meanings in another, as Hodgkin cogently argues:

> unless we are to diagnose entire cultures as psychotic, we have to rethink the question of what counts as mad, locating it in social and cultural definitions rather than assuming a transhistorical identity of the insane.
>
> (Hodgkin, 2007: 4)

Part of my preference for the word madness therefore lies in its sustained use across histories and cultures. It is what Bakhtin refers to as a *Great-time* word, a phrase that refers to words of the past transferring from one historical period to another, whilst maintaining the essence of their meaning (Good, 2001: 82). It is important to note that whilst *Great-time words* may endure as words, their meaning is not fixed, but shifts according to the context in which it they are uttered in. Bakhtin compares *Great-time words* with *Small-time words*, official terms that fall out of fashion; for example *asylums* became *psychiatric hospitals*, which in turn became *clinics* or *psychiatric units*. Mental illness may indeed turn out to be another small-time word, its longevity as a construct questionable; but madness, I believe, will endure. Madness is also a term that is being reclaimed by survivors, another small-time word that replaces terms such as patients, clients and users. Mad Pride, for example, is a social action movement where dominant definitions of people's experiences are not only challenged, but also celebrated as madness. As a narrative researcher, the decision to use the word mad had a critical impact on the direction of this study, as it allowed me to focus on the philosophical and hermeneutic aspects of their people's experiences, rather than examining their distress as an object of medical science.

One further term related to the experience of madness that underpins chapter three of this thesis is 'schizophrenia'. In chapter three, I use schizophrenia as an example of how science has created a disease construct with little supporting evidence, exploring how such terms enter into the public consciousness. It is also a term applied to both Margery Kempe and Mary Barnes. When I refer to 'schizophrenia' in this research, I am not referring to it as a syndrome, illness or medical object. Rather, as I shall argue in chapter three, I am referring to it linguistically as a social construct, a construct that Barrett argues demands a sociological account of the institutional practices and cultural traditions that have shaped and defined it as a scientific category (Barrett, 1998). As stated earlier in relation to madness, this is not to deny what for some is a traumatic and intensely disturbing experience. Rather I wish to highlight how the use and dissemination of such constructs has been used to augment the authoritative voice of science, marginalising not only alternative explanations, but crucially the meaning of experiences from dialogues about madness. One of the aims of this research is to identify the metaphors that those labelled schizophrenic and psychotic have used to make sense of their experiences. For the purposes of this thesis, therefore, my position towards the term 'schizophrenia' shall no longer be signified by quotation marks, but the reader should note that linguistically it is referred to as a social construct and not a medical object.

The final term used in this thesis that requires careful definition is recovery. Recovery is undoubtedly an abstract concept, a linguistic construction that is applied to people's lives in a generalised way. It has within it linear connotations of progression, moving forward, and is often accompanied by linear metaphors (road, path and journey).

Recovery is often used in relation to its foremost dictionary definition "a return to a normal state of health, mind or strength" (The Oxford Pocket Dictionary of Current English, 2008). The use of the word 'recovery' within this definition therefore becomes problematic for this research, bearing in mind that one of its fundamental arguments is to challenge definitions of 'normal' and 'health'. Other metaphors can be used to describe this process. What many people who have had unusual and, at times, distressing experiences describe is a loss of self, and in this sense recovery takes on a subtly different meaning, "the action or process of regaining possession or control of something stolen or lost" (The Oxford Pocket Dictionary of Current English, 2008). Whilst this definition may come closer to people's experience, it still has an underlying linearity, as the direction of time is reversed in order to recover that which is lost. I will argue, however, that following madness, there is no regaining that which is lost; rather there is a process of reconstruction as the self is fundamentally changed. The word reconstruction is based on a rebuilding or re-creation of the self and does not contain the temporal, linear connotations associated with recovery. It is, as Corin and Lauzon describe, "a reopening to the world" (1992: 276). This said, I do not want to dispense with the word recovery; as a word, its cultural positioning in the discourse of madness is of critical importance. Rather, I want to use the word recovery in more radical ways than its dictionary definitions, putting forward the argument that recovery is reconstruction.

Theoretical basis: Michel Foucault and Mikhail Bakhtin

To reiterate, the aim of this research is to explore the relationship between madness, narrative, understanding and recovery both pre and post psychiatry. To delve into people's histories of madness necessitates situating them in the wider histories of

madness. Foucault is therefore the first of two key theorists whose work underpins the development of the arguments presented in this thesis. Three texts in particular were consulted: *History of Madness, Psychiatric Power* and *Discipline and Punish*. Through these works, which form the basis of chapter two, Foucault presents three interrelated histories: a history of the division between madness and reason, a history of institutions and a history of power. What I have attempted to do in this research is to interweave these histories in order to illuminate the ways in which they are mutually dependent. For Foucault, the division between reason and unreason marked both the silencing of madness and the development of psychiatry, making madness fundamentally a discourse of power. However, Foucault could be accused of displaying the mad as objects of academic scrutiny, with his as the authoritative voice rather than that of the mad. For example, Ingleby, whilst not referring specifically to Foucault, argues that patients are "conspicuously absent" from historical studies, encouraging "some authors to treat them almost as epiphenomena of psychiatry itself" (Ingleby, 1983: 144). What this research aims to do is to place the voice of the mad at the centre, not as a phenomenon of psychiatry, but as an experience worthy of expression outside of the voice of science. That said, Foucault's work is important to this research in two key respects. First, his writings provide the pre and post psychiatry context needed to situate the narratives chosen for this research. Particularly useful is his analysis of the three eras that defined the division between madness and reason in Europe from medieval times to the 1900s, which challenges the progressive and linear development of the narrative of psychiatry, focussing instead on the power of language and discourse in the development of institutions and technologies. In this research, I too challenge the hegemonic, linear narrative of psychiatry and its institutions, but I challenge it within the wider Western assumptions of what narrative means, in particular what

narrative means to the mad. So whilst this research incorporates the broader cultural arguments that Foucault espoused, where I depart from Foucault is in my focus on the meaning of the individual experience within the narrative structure. Second, this research has been informed by Foucault's writings on power, subjectivity and resistance. The ways in which power became embodied through psychiatry, its institutions, technologies and discourses is central to the analysis stage of this research. Particularly important is Foucault's coupling of power and resistance, a space where power is exercised through the relationship between two parties. Using Foucault's framework of power, I shall argue that both Barnes and Kempe resisted traditional cultural definitions of both female roles and madness, and by such resistance became empowered as individuals, albeit in a fairly precarious position in relation to male authority.

Mikhail Bakhtin, the critical literary theorist and philosopher, is the second key writer whose work underpins this thesis. Bakhtin writes of power in a slightly different way to Foucault, focussing less on institutions and more on the specifics of language, yet it is their common interest in discourse that draws these theorists together for the purposes of this research. Bakhtin argues, like Foucault, that dominant groups such as psychiatry that emerged relatively quickly in response to sudden cultural changes, attempt to impose an authoritative discourse which, through the assertion of its power, marginalises other discourses (Bakhtin, 1981). His argument that authoritative discourse is a way of maintaining hierarchical relations within the dialogical relationship, fits with Foucault's descriptions of institutional discourses creating and maintaining relationships between power and knowledge. What Bakhtin adds to Foucault however, is a focus on dialogue and the way it reaches both into the past and

future through the dialogical relationship. His distinction between two forms of discourse, monological and polyphonic, was critical to the analysis stage of this research, in particular his identification of ancient literary genres which precede the emergence of polyphony. A second aspect of Bakhtin's work that has been pivotal not only to my understanding of Barnes' and Kempe's narratives, but also aided my understanding of the historical context of this research, is Bakhtin's concept of the 'chronotope'. Chronotope literally means time-space and refers to the ways in which time and space are represented internally within the narrative, for example through metaphor, and also externally through the relational positioning between narrative chronotopes and wider societal and cultural chronotopes. Bakhtin argues that transformations in the narrative chronotope are related to historical transformations in an individual's life, which in turn is related more widely to societal changes. Of particular significance in examining the ways in which madness, narrative, understanding and recovery are related is Bakhtin's notion of the threshold chronotope. This chronotope is a time of crisis and break and is characterised in the narrative by both anxiety and acts of boldness. As Bakhtin describes it, "time is essentially instantaneous; it is as if it has no duration and falls out of the normal course of biographical time" (Bakhtin, 1981: 248). I shall argue, particularly in Barnes' narrative, that it is at these critical points of disjuncture that psychological movement and change occurs.

Research Question

The genesis of this research, together with extensive reading of the literature on the history of madness, illness narratives and narrative methodology, leads to one key question; what is the relationship between madness, narrative, understanding, identity

and recovery? In order to answer this key question, a sub-question, which will aid the analysis and help answer the primary question, is oriented around the metaphors used to construct meaning and how these change in relation to the cultural and historical context. Bakhtin's work, in particular his focus on voice and context, will be central in answering these questions. Locating the different voices in the text and examining the dialogical relationship between them allows identification of cultural and historical themes, whilst enabling me to distinguish the purpose and intended recipients of the narrative.

Structure of Thesis

This introduction is followed by chapter two, *History of Madness and Psychiatry*, which, as outlined above, aims to bring together Foucault's histories of madness and reason, institutions and power. Whilst Foucault is the dominant theorist drawn upon for this chapter, his work is complemented and, at times, contrasted with fellow historians Roy Porter and Klaus Doerner, and leading sociologists such as Andrew Scull and Nikolas Rose, all of whom have written extensively on the history of psychiatry from a critical perspective. The chapter gives a broad overview of these histories from the Pre-Enlightenment to the impact of current Government legislation, encapsulating major movements such as moral treatment, the Reform, the growth of the asylum and anti-psychiatry. Whilst this is an ambitious chapter in its scope, it hopefully captures the complexities of Foucault's interweaving histories.

Chapter three, *Constructions of Madness*, focuses on a specific debate in the history of madness and psychiatry - the concerns around the legitimacy of diagnosis, examining this through two divergent narratives: the narrative of psychiatry and the narrative of

social constructionism. Taking schizophrenia as an example, the chapter critically reviews the evidence supporting schizophrenia as a diagnostic category on two levels. First, drawing on the work of Mary Boyle, it challenges the validity of schizophrenia as a scientific construct, arguing that there are fundamental epistemological and ontological flaws that go against such classification. Second, the chapter reviews the key research areas used to support the notion of schizophrenia as a biological phenomenon. The second part of the chapter examines an opposing view, that the term schizophrenia is a social construct. Using the work of Theodore Sarbin in particular, I shall argue that language, metaphor and context are central to both the experience of schizophrenia and an individual's communication of meaning to the other. The chapter closes by arguing that the polarisation between the biological and social determinism debate, and the division between different schools of thought, is not in the interest of the individual. Instead I shall argue that a pluralist view needs to be taken, one where perspectives can be integrated, but crucially one where the expert voice is that of the experiencer.

Chapter four, *Bakhtin and Narrative Psychology*, leads away from the professional-as-expert and academic-as-expert narratives described in chapters two and three, by exploring the concept of the patient-as-expert narrative. The chapter introduces the work of Bakhtin as a means of examining the narrative as a space of dialogical activity and a space where the unfinalised self is explored and transformed within complex understandings of time. The chapter then moves on to briefly examine the literature around illness narratives. The wealth of narrative research in this area, compared with the dearth of narrative research on madness, demands an explanation that I offer in relation to narrative dispossession and an over-commitment to linear narratives. I shall

argue that madness narratives are mostly invalidated by professional groups, for example as symptoms of illness, and if they are used, they are in such a way that supports the dominant narrative of psychiatry. Such stories should not be ascribed to narrative loss, but to narrative dispossession.

Chapter five is concerned with method and ethics. Much of this thesis argues against science for the understanding of madness, and, as such, I have purposefully distanced myself from the scientific language that traditionally surrounds social science research. Instead, I take my terminology from the field of phenomenology and hermeneutics, both of which underpin the view of narrative research followed in this research. Whilst opting for a broader narrative analytic approach used, for example, by Arthur Frank and Arthur Kleinmen, over a more structuralist approach traditionally used in interviews, for example by Mishler and Riessman, I aim to tackle the difficult issues of validity and ethics. It is in this chapter that I introduce the two narratives for analysis, Kempe and Barnes, outlining the reasons for this choice, and the decisions and dilemmas that led up to this.

Chapters six and seven constitute the analysis stage of this research. Chapter six focuses on Margery Kempe and her medieval narrative of madness. It explores Margery's understandings of both her madness and her mysticism, examining how she negotiated the boundaries between the two and how she communicated her understanding through metaphor. The second part of the chapter goes on to explore the impact of Margery's mad/mystical experiences on her social positioning. These two themes, madness/mysticism and social belonging, can be construed as chronotopes and are brought together in a literary genre Bakhtin refers to as 'the adventure chronotope of

everyday life', which, I argue, allows Kempe to present Margery's life as one of metamorphosis and transformation (Bakhtin, 1981: 111). Rather than her narrative being interpreted from present day perspectives as one of mental illness as some have done (Claridge, Pryor and Watkins, 1990; Craun, 2005; Drucker, 1972), I suggest it should be read within the religious framework in which it was written, so it becomes less a narrative of madness and more a narrative of a would-be saint.

Chapter seven turns to Mary Barnes, a woman who, whilst centuries apart from Kempe, has much in common with her. Barnes' book is a complex narrative that draws on multiple metaphors to articulate her experiences, which are predominantly embedded in psychodynamic theory. As with Kempe's analysis, my interpretation of Barnes' narrative was aided by Bakhtin's work on literary genres, voice and chronotopes. I compare Barnes' narrative and the Laingian anti-psychiatry movement in which her experience and narrative are embedded with Rabelais' carnival, examining how the grotesque temporarily suspends and inverts hierarchies, yet how, at heart, these hierarchies remain strong. My analysis of Barnes concludes by examining the temporal and spatial structure of her narrative. I argue that whilst it has a strong linear framework, it has within it complex chronotopes of madness, recovery and transition, that makes Barnes' experience, at times, very medieval.

Chapter eight is a discussion chapter that aims to draw the analysis of Kempe's and Barnes' narratives together, exploring their similarities and differences, looking at how these deepen understandings of madness and what their stories can tell us of the nature of recovery. I discuss why Kempe primarily identified herself as mystical, whereas Barnes identified herself as primarily mad, and whether indeed there are any differences

between these two states. I then go onto explore whether an argument can be made for their stories being narratives of recovery, addressing how metaphors of recovery, whilst traditionally linear, are in fact more complex, questioning if not the usefulness of the word recovery, then at least its definitions, as I argued earlier. Central to recovery for Kempe and Barnes was the state of liminality as a subjective experience, a liminality that is also reflected in the social sphere, as I illustrate how these women resisted the male hegemonic voices of religion, psychiatry and gender. Liminality and ambiguous social positioning enable both Kempe and Barnes to engage with a realm of possibilities, becoming different people, having different lives and telling different stories from those culturally scripted for them. They become, as Bakhtin describes, unfinalised, and, I argue, it is Bakhtin's narrative genres that provide a space which enables the search for meaning and the transformation of the self.

The thesis concludes by restating the argument that patients have become disengaged from their stories, yet it is these very stories that are central to recovery. They are, as articulated by theorists such as Frank, Kleinman, Charmaz and DeSalvo, a powerful way to alleviate suffering. By exploring the ways in which madness, understanding and recovery have been approached within narratives across history, insights can be gained that may help to re-establish the centrality of stories and understanding in contemporary healthcare. Acknowledging an individual's narrative agency and attending to the meaning within seemingly chaotic, senseless speech is pivotal for recovery in several respects. First and foremost, it validates the person's experience. Second, attention to meaning provides a bridge between the individual and the clinician, thus helping to establish a dialogical relationship. This can help shift the focus away from the doctor/patient relationship as a medical intervention, redefining the boundaries around

the voice of the patient in partnership with that of the medic. This would require, on behalf of the doctor, attention to the seemingly incoherent, fragmented small stories of an individual's speech, focussing on metaphoric meaning as opposed to the form of speech. If this dialogical space is created, it is possible that an explanation for disturbing experiences can be arrived at in dialogue, which is consonant with the individual's values, belief systems and culture. Third, by engaging the patient in shared dialogical activity, s/he can have an active role in their recovery, thus there is a greater possibility that they can manage future disturbing episodes, requiring less medical intervention such as hospitalisation. Taking responsibility for recovery also raises self-esteem, self-efficacy and instils hope. Attention to meaning via people's stories is fundamentally a moral objective, where restoring personhood becomes the aim. What is argued for within this study is not a dismissal of scientific and biomedical explanations, but a framework that places patients' stories central to clinical care. More space needs to be given to these contextual explanations, but not to the exclusion of emerging biological explanations. By locating madness narratives in wider frameworks of power and building a strategy that tells the stories of others to a wider audience, my modest hope is to increase awareness of the role and power of stories in the clinical arena.