Advances in Psychiatric Treatment (2003), vol. 9, 265–271

Autobiographical narrative and psychiatry

Femi Oyebode

Abstract This paper addresses how mental illness and psychiatry are presented in autobiographical narratives. The richness of clinical psychopathology unmediated by the expectations of psychiatry is described. The rituals of psychiatry, the importance of the personal relationships between patients and clinicians, and the subjective beliefs of people about mental illness are explored.

This paper continues the series on literature and psychiatry. Previous papers introduced cognitive linguistics and metaphor (Eynon, 2002), literature and substance misuse (Day & Smith, 2003) and death and dying in literature (Skelton, 2003; invited commentaries by Sims, 2003, and Murray Parkes, 2003). Future papers will consider, among other things, how dementia is described in fiction and biography.

Since St Augustine of Hippo's *Confessions*, written between 397 and 398, autobiographies have come to combine self-analysis and honest personal disclosure. It is therefore not surprising that there are autobiographical accounts of mental illness, for honest self-disclosure has cachet only when the material that is disclosed is taboo. Thus, the *Confessions* was a remarkable work because it dealt with the saint's previous life of sin, especially his sexual weaknesses. However, it would be wrong to imply that autobiographical accounts of mental illness have all been written merely to be revelatory. There are accounts, such as J. S. Mill's *Autobiography* of 1873 and Janet Frame's *An Autobiography* (1990)[1], that set the author's experience of the illness in the context of a life, so that the account of mental illness sits appropriately within the trajectory of an existence that has other purposes and goals. There are other accounts, such as Fiona Shaw's *Out of Me* (1997) and Tim Lott's *The Scent of Dried Roses* (1996), which are as much about the experience of mental illness as the attempt to make sense of that experience. There are also accounts, such as Lewis Wolpert's *Malignant Sadness* (1999), that are examples of public health education of a refined kind. Sarah Ferguson's *A Guard Within* (1973) is distinct, in that it is epistolary in nature and is addressed to her deceased psychiatrist.

Autobiographical narratives of mental illness are unique sources of information. They allow psychiatrists and other mental health workers a rare insight into the richness of psychopathology as experienced, rather than as drawn out and described by psychiatrists. Furthermore, the impact of psychiatric illness and the consequences of being 'labelled' on the identity and social life of individuals can be more forcefully described. The variety of folk understanding, what is now technically termed health belief, is also revealed and given validity such that it challenges the perspective of psychiatry. The many rituals of psychiatry, the pernicious and restricting environment of hospitals and the importance of personal relationships with clinicians are all exposed and discussed in autobiographical narratives. It is evident that psychiatrists would benefit from reading autobiographical narratives. It is also an opportunity to become familiar, in a safe and unthreatening manner, with what our patients think of us and the services we provide. Books, at least, can be read in privacy. The emotionally charged views of many of our patients can be confronted without the impulse to become defensive. However, not all autobiographical accounts are critical of psychiatry or psychiatrists. And those that are deserve to be read and understood.

The aim of this paper is to examine the main themes found in autobiographical narratives. For this purpose, I have excluded autobiographical novels such as Janet Frame's *Faces in the Water* (1980). I have also excluded fictional works such as Patrick McGrath's *Spider* (1990) that treat mental illness or asylums as major issues. Journals and poetry have also been excluded. My choice of books is not exhaustive. There is an established tradition of borrowing from autobiographical narratives of mental illness. Jaspers, in his *General Psychopathology* (1913), borrowed from Schreber's *Memoirs of My Nervous Illness* (1955). Indeed, Freud (1911) and Sass (1994) have based their own notions of delusions on Schreber's *Memoirs*. In many respects,

1. Books are not necessarily referenced to their first editions.

Femi Oyebode is Professor and Head of the Department of Psychiatry at the University of Birmingham (Department of Psychiatry, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ, UK).

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press

all psychiatrists owe a debt to Schreber, whose writing has helped to illuminate psychopathology and shape our understanding of psychotic experiences. This fact further underlines the importance of autobiographical narratives to psychiatry.

Psychopathology

Mood disturbance

Writers as diverse as J. S. Mill and Tim Lott describe their experience of mood disturbance with exceptional clarity. Mill's description of anhedonia, which appears in his *Autobiography* of 1873, stands out:

> 'It was the autumn of 1826. I was in a dull state of nerves, such as everybody is occasionally liable to; unsusceptible to enjoyment or pleasurable excitement; one of these moods when what is pleasure at other times, becomes insipid or indifferent… In this frame of mind it occurred to me to put the question directly to myself, "suppose that all your objects in life were realised; that all the changes in institutions and opinions which you are looking forward to, could be completely effected at this very instant: would this be a great joy and happiness to you?" And an irrepressible self-consciousness distinctly answered, "No!" At this my heart sank within me' (1989 reprint: p. 112).

Mill's intention in his autobiography was not to write about mental illness, thus he did not dwell for long on this aspect of his life. Neither did he understate or minimise his experiences. We are aware of the recurrence, severity and impact of his depressive episodes. We see that he considered suicide, but there is no melodrama in the account. We are left with the impression of an active intelligence, a generous spirit who is totally committed to human progress. His childhood and prodigious talent, his extraordinary erudition and accomplishments put his experience of depression into context.

In contrast to Mill's description of loss of enjoyment, we have William Styron's evocation of the anguish of depression: 'I was feeling in my mind a sensation close to, but indescribably different from actual pain' (1990: p. 16). This analogy between depression and physical pain recurs in many writers. Writing in 1902, William James described depression as follows: 'It is a positive and active anguish, a sort of psychical neuralgia wholly unknown to normal life' (1999 reprint: p. 165). For others, the intangibility of the emotional pain drives the individual to inflict actual physical harm that will result in real, that is, physical pain. For example, Sarah Ferguson wrote 'The pain is so unbearable inside me that a force of such strength has driven me to inflict a physical pain on myself in the hope of appeasing the other' (1973: p. 166).

Fiona Shaw's description of the effect of depression on how she experienced her body is worthy of note because it touches on an aspect of depression that is not remarked upon in standard textbooks:

> 'My body became inert, heavy and burdensome. Every gesture was hard.
>
> '… My existence was pared away almost to nothing, except for the self-contempt that bruised my eye sockets and throat, that turned my stomach and made my tongue into some large, coarse creature in my mouth' (Shaw, 1997: p. 26 & p. 27).

The relationship of depression to the loss of faith and hope is ever present in these narratives. There is also the inevitability of suicide. The pervasive, obtrusive and inescapable reality of suicide is underappreciated by clinicians. Styron described how:

> 'many of the artefacts of my house had become potential devices for my own destruction; the attic rafters (and an outside maple or two) a means to hang myself, the garage a place to inhale carbon monoxide, the bathtub a vessel to receive the flow from my open arteries' (p. 52).

Jamison, in her book *An Unquiet Mind* (1995), described how, once she had decided to end her life, she 'was cold-bloodedly determined not to give any indication of my plans or the state of my mind' (p. 113).

This efficient and detached approach to suicide is echoed in Clifford Beers' book, *A Mind that Found Itself* (1907). Beers, like Styron, described how suicidal thinking compels the individual to consider various methods that may be used. In Beers' case, he chose jumping from a height and survived. His deliberate deception of his parents and relatives as to his intentions is instructive to psychiatrists. Once he had decided on a method, he distracted his parents' attention from the severity of his condition by behaving as normally as possible. The compulsive nature of suicidal thinking and the tendency to deceive others once the decision to make an attempt has been reached should be more widely understood by all clinicians but perhaps more so by the nurses who have charge of patients on a day-to-day basis.

Jamison described the experience of manic elation very well and also the transition from joyful elation to dysphoric elation:

> 'When you're high it's tremendous. The ideas and feelings are fast and frequent like shooting stars and you follow them until you find better and brighter ones. Shyness goes; the right words and gestures are suddenly there, the power to captivate others a felt certainty. There are interests found in uninteresting people. Sensuality is pervasive and desire to seduce and be seduced irresistible… But somewhere this changes… Everything previously moving with the grain is now against – you are irritable, angry, frightened, uncontrollable, and enmeshed in the blackest caves of the mind' (1995: p. 67).

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press

Psychoses

There is a dearth of good descriptions of psychotic experiences compared with descriptions of mood disturbance. This difference is perhaps understandable given the effects of schizophrenia on motivation, drive and use of language. Schreber's account of his psychoses (1903) and Beers' description of his illness (1907) are two outstanding examples of descriptions of psychotic experience. It is not the intention of this paper to discuss the clinical diagnoses of these authors but rather to use their writings to illustrate some aspects of psychotic experience. The interested reader will find much of value in the two books. Both Schreber and Beers described what is a now termed delusional misidentification syndrome. The example below is from Beers' book:

> 'I soon jumped to a second conclusion, namely, that this was no brother of mine at all. He instantly appeared in the light of a sinister double, acting as a detective. After that I refused to speak to him again, and this repudiation I extended to all relatives, friends and acquaintances. If as I had accepted my brother was spurious, so was everybody … For 2 years I was without relatives or friends, in fact, without a world, except that one created by my own mind from the chaos that reigned within it…
>
> 'Though they all appeared as they used to, I was able to detect some slight difference in look or gesture or in intonation of voice, and this was enough to confirm my belief that they were impersonators, engaged in conspiracy, not merely to entrap me, but to incriminate those whom they impersonated' (1907: p. 23 & p. 52).

Schreber's *Memoirs* (1903) is instructive in many respects. We find a superior intelligence describing and commenting on his experiences. He also analyses psychiatric conceptions of psychopathology, drawing on the literature of his day:

> 'By hallucinations one understands, a far as I know, stimulation of nerves by which a person with a nervous illness believes he has impressions of events in his external world, usually perceived through the sense of seeing or hearing, which in reality do not exist. Science seems to deny any reality background for hallucinations, judging from what I have read for instance in Kraepelin's PSYCHIATRY, Vol. 1, p. 102 ff. 6th edition. In my opinion this is definitely erroneous, at least if so generalised' (1955 reprint: p. 223).

Schreber described a multitude of hallucinatory and passivity experiences. What is remarkable is the degree to which he retains a self-observant consciousness. He informs us that:

> 'For almost 7 years – except during sleep – *I have never had a single moment in which I did not hear voices.* They accompany me to every place and at all times; they continue to sound even when I am in conversation with other people, they persist undeterred even when I concentrate on other things' (1955 reprint: p. 225).

His description of passivity experiences is exceptional:

> 'My fingers are paralysed, the direction of my gaze is changed in order to prevent my finding the right keys, my fingers are diverted on to the wrong keys, the tempo is quickened by making the muscles of my fingers move prematurely' (1955 reprint: p. 144).

Schreber's *Memoirs* is likely to continue to be influential. It contains some of the best descriptions of psychotic experience.

The rituals of psychiatry

William Seabrook's *Asylum* (1935) was written simply to describe his experience of treatment for alcohol abuse in an American asylum in the early 1930s. As he says, 'I am not a reformer of public opinion or a propagandist. I am an adventure writer of sorts, and I write this mainly as the story of a strange adventure in a strange place' (p. 12). He noted that the doctors and nurses 'write down everything a patient says especially about death, escape or suicide'. His description of the initiation rules included the shower and the weighing on admission. All property, including watch and clothing, were taken away on admission and the patient had to sleep with the door open and the lights on. He commented, 'It was a strange world in which I was still a neophyte. It had its rituals – psychiatry sometimes seems crazier than any of the patients it treats' (p. 49). In contrast, Clifford Beers' *A Mind that Found Itself* (1907) is a campaigning book. His cataloguing of the instruments of restraint and their effect on the patient deserves to be read. These instruments included straightjackets, camisoles, muffs, straps and mittens. The use of the muff to restrain the patient at night, while the single attendant sleeps, and also as a means of discipline on 'account of supposed disobedience', gives an insight into the physically coercive environment in which psychiatry was practised. He describes the use of seclusion:

> 'Acting on the order of the doctor in charge, one of them stripped me of my outer garments; and, clad in nothing but underclothes, I was thrust into a cell. Few, if any, prisons in this country contain worse holes than this cell proved to be. It was one of five, situated in a short corridor adjoining the main ward. It was about 6 feet wide by 10 long and of a good height… The walls and floor were bare, and there was no furniture. A patient confined here must lie on the floor' (p. 124).

Beers described how the brutalising environment coarsened the sensitivity of newly appointed

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press

young attendants such that, soon after being appointed, they became as harsh as the others. Furthermore, he described how the harsh and violent environment made him more hostile and violent. He wrote:

> 'Deprived of my clothes, of sufficient food, of warmth, of all sane companionship and of my liberty, I told those in authority that so long as they should continue to treat me as the vilest of criminals, I should do my best to complete the illusion' (p. 146).

He argued that more fundamental than technical reform, cure or prevention was the need for a changed spiritual attitude towards the insane. Beers succeeded in describing the perverse structures and oppressive regime of the early-20th-century American psychiatric system. It is easy to be self-congratulatory, particularly because of the absence of physical restraints and overtly punitive regimes in modern psychiatric hospitals. However, our wards are still permeated and characterised by a lack of respect for patients; a subtly coercive atmosphere still presides. It is true, too, that an unreflective and inhumane indifference to anguish can still be observed. The situation is complicated by a worsening intolerance by the public and undue emphasis by the political class and media on risk rather than care and compassion. Beers, sadly, is still relevant today.

Relationship with doctors

Sarah Ferguson's *A Guard Within* (1973) is written in the style of a letter to her deceased psychiatrist. It is illustrative of intense grief. It reminds us of the power of the therapeutic encounter. Even though the relationship that we witness was born and nurtured within a psychotherapeutic relationship, it is a signpost to the nature of the relationship that patients have with their doctors. Ferguson's writing shows how real this very unreal and special relationship is to patients. It illustrates the dangers of crossing the boundaries between the abstract fantasy world in which psychotherapy trades and the crude reality of the mundane exchange within the here and now. This is not the place to discuss the moral and technical dimensions of Ferguson's relationship with her therapist. Descriptions of physical contact with her therapist reveal how important this was:

> 'One day, after many troubles, you were holding me, and my head was just touching your face, and I became stronger than you, and you became mine … my head was only just touching your face. We never spoke of it… I tell you, it became easier to be with you then (but not noticeably so), and my trust in you grew, that is all (p. 31).

> '... If our relationship had been exposed to a crowd, it would have been damaged; not broken, because it was strong and unbreakable… Only under our own terms could it grow. It might have perished under a public glare because it was so real and true. There was no pretence' (p. 120).

The book is particularly tragic because we know that in the end the author does not survive; that she kills herself.

The third volume of Janet Frame's *An Autobiography* (1990) is entitled *The Envoy from Mirror City* and describes her relationship with Dr Cawley at the Maudsley Hospital. The chapter entitled 'Dr Cawley and the luxury of time' describes her introduction to the doctor and explains why she took to him readily. She wrote:

> 'I think I was able to accept Dr Cawley because I was aware that his view was wider, over a range of studies and disciplines and personal experience, just as I had readily accepted Dr Miller because I knew he was interested in music and art. The qualifications of medicine and psychiatry were extensions of these men, not starting and ending points (p. 383).
>
> 'I now had confidence in Dr Cawley, for I had not only seen myself developing and growing in his care, I had observed his own development as an assured psychiatrist who, I felt, would always respect the human spirit before the practice, the fashions and demands of psychiatry' (p. 385).

It is obvious that our patients have views about us, about our personality, our attitudes and approach to psychiatry. It is too easy to forget that, just as we appraise the patient, we too are being appraised, assessed and judged. The therapeutic encounter is two-way.

Impact of diagnosis and labelling on social life

Janet Frame's autobiography (1990) describes her experiences of institutional psychiatry in New Zealand and Britain and the lasting impact of these experiences on her. Both in this work and her autobiographical novel, *Faces in the Water* (1980), we learn how an individual can come to be processed through the psychiatric system and how the system, with its varied rituals, can strip an individual of identity and the sense of agency. The labels we use, no matter how valid, can have a force above and beyond clinical utility. It is as if the act of naming itself carries prognostications, like a shaman's pronouncement, both magical and social, that can imperil the patient's life. Frame wrote:

> 'I suffered from *schizophrenier*. It seemed to spell my doom, as if I had emerged from a chrysalis, the natural human state, into another kind of creature (p. 196).

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press

> 'I was taking my new status seriously. If the world of the mad were the world where I now officially belonged (lifelong disease, no cure, no hope), then I would use it to survive, I would excel in it' (p. 198).

This new status had social implications:

> 'I was in hiding. I was grieving. I didn't want anyone to "see", for once I had been in hospital, I had found that people didn't only "see", they *searched* carefully' (p. 211).

Frame helps us to see how, once labelled and treated as mentally ill, a person can become 'other', separated spiritually and socially from family and society. A sense of loneliness, of not belonging and of constantly being under scrutiny ensues and undermines confidence. This can result in the patient readily seeking asylum in the company of people designated as mentally ill, despite the fact that the asylum is neither welcoming nor a healthy refuge. Frame also helps us to see that a self-imposed restraint exists. Lack of confidence, shame and fearfulness combine to entrench a person further in misery.

Seabrook understood the influence of institutionalisation:

> 'No responsibilities, no obligations, no problems to meet or solve, no duties or decisions. We didn't even have to decide when to get up in the morning or when to go to bed. Somebody else looked after us… so that, cured now, outside… I remember the haven it was – almost wish sometimes I were back there' (1935: p. 68).

Understandings of emotional disorders

Tim Lott's *The Scent of Dried Roses* (1996) was written in the wake of his mother's death by suicide. Lott had himself just recovered from a depressive episode prior to his mother's death. In this book, he attempts to give meaning to both his mother's suicide and his own depression. In this, he is similar to other writers. Where he differs significantly is in the terms under which he operates. While in *Out of Me*, Fiona Shaw (1997) predictably locates the problems in the internal world and in problematic relationships with her father, and Lewis Wolpert, in *Malignant Sadness* (1999), approaches the subject as a scientist, and a biological scientist at that, Lott prefers a social explanation. What he has in common with most writers on this subject is his refusal to accept that depression is merely the result of biochemical anomaly. For Lott, his mother's suicide and his own depression can both be understood as reflecting the decay of English self-confidence, loss of identity and the degradation of society during the 1970s and 1980s, exemplified by the deterioration of Southall. This is a version of Durkheim's ideas about the social origins of human behaviour. Lott understands the problems and gives his explanations:

> 'It doesn't add up, it doesn't cut a swathe that is clear. For if my mother and I were simply ill, am I not wasting everyone's time? England, history, family, love, regret, identity, meaning. Does their poetry fall apart under the prose of science? Is it as absurd as looking for the meaning of a headache in history, the meaning of cancer in culture?' (p. 196).

Fiona Shaw (1997) expresses the same disquiet but from a different perspective:

> 'There was no scepticism and no psychology. Lives, it seems, can be described as illnesses and organised in just the same way as organic disease would be.
>
> 'The psychiatrists were never interested in the words I chose. Words had only one side to them, as far as they were concerned; storymaking was all very well so long as it didn't go too far' (p. 156 & p. 175).

What do these understandings or readings mean for psychiatrists? Unlike physicians, psychiatrists cannot ignore the social and personal meanings of illness. We cannot be indifferent to the compulsion that patients have for a coherent narrative of causation that moves outside the mechanistic materialism of biochemistry. For most patients, the explanations for their emotional disorder reside within the social world. Psychiatry does not need to adopt or even endorse these particular narrative explanations. However, our professional narratives of causation must at least be open to dialogue and, as individual clinicians, we must understand the motifs that are readily used by our patients.

Conclusions

Autobiographical accounts of the experience of psychiatric illness provide an insight into the nature of psychiatric disorders in a way that is not possible from standard psychiatric texts. The hope is that these accounts will help to enrich the language and thought of psychiatrists. The subjective, the personal, the social and cultural context are hallowed ground in autobiography, whereas, in psychiatric texts, it is the objective and general that is stamped and reinforced. The foregoing is only a fragment of what the autobiographical narratives contain.

References

Beers, C. W. (1907) *A Mind that Found Itself. An Autobiography*. New York: American Foundation for Mental Hygiene.

Ferguson, S. (1973) *A Guard Within*. London: Chatto & Windus.

Frame, J. (1980) *Faces in the Water*. London: Women's Press.

—— (1990) *An Autobiography*. London: Women's Press.

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press

Freud, S. (1911) Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides). Reprinted (1953–1974) in the *Standard Edition of the Complete Psychological Works of Sigmund Freud* (trans. and ed. J. Strachey), vol. XII. London: Hogarth Press.
James, W. (1902) *The Varieties of Religious Experience*. Reprinted (1999). New York: The Modern Library.
Jamison, K. R. (1995) *An Unquiet Mind. A Memoir of Moods and Madness*. New York: Knopf.
Jaspers, K. (1913) *General Psychopathology*. Reprinted (1962): trans. J. Hoenig & M. W. Hamilton. Manchester: Manchester University Press.
Lott, T. (1996) *The Scent of Dried Roses*. London: Penguin.
McGrath, P. (1990) *Spider*. London: Penguin.
Mill, J. S. (1873) *Autobiography*. Reprinted (1989): ed. J. M. Robson. London: Penguin.
Sass, L. A. (1994) *The Paradoxes of Delusion. Wittgenstein, Schreber and the Schizophrenic Mind*. Ithaca, NY: Cornell University Press.
Schreber, D. P. (1903) *Memoirs of My Nervous Illness*. Reprinted (1955): trans. I. Macalpine & R. A. Hunter. London: Wm. Dawson & Sons.
Seabrook, W. B. (1935) *Asylum*. London: Harrap.
Shaw, F. (1997) *Out of Me*. London: Penguin.
Styron, W. (1990) *Darkness Visible. A Memoir of Madness*. London: Cape.
Wolpert, L. (1999) *Malignant Sadness. The Anatomy of Depression*. London: Faber & Faber.

INVITED COMMENTARY ON

Autobiographical narrative and psychiatry

Lewis Wolpert

Oyebode (2003, this issue) suggests that autobiographical accounts of mental illness provide psychiatrists with a valuable source of information as to the nature of that condition. I am not really sure that he is right. It is hard to see what effect it has had on the treatment of patients or the understanding of mental illness. As someone who has experienced severe clinical depression, there is nothing I have read that I can recognise as corresponding to my experience, although William Styron's (1990) *Darkness Visible* probably comes closest. I think the problem is that, in severe depression, one enters a state that bears no relationship whatsoever to the feelings one has had in one's previous experience. This is a point well made by William James (1902). My current, rather bitter view, is that if you can describe your severe depression you have not really had one. And this may account for the almost total absence of good descriptions of depression in the classical corpus of English literature. Considering that depression affects around 10% of the population, and perhaps writers even more, it is astonishing that such descriptions are absent. Virginia Woolf, herself a sufferer from depression, did not include a description in any of her novels. It may be just too hard.

However, I have not yet read Schreber's (1955) *Memoirs of My Nervous Illness*, which Oyebode sees as being of singular importance. One must offer Oyebode's paper and views strong support, since psychiatrists or other mental health workers who have not personally experienced depression, for example, must have enormous difficulty understanding their patients' problems, rather like a dentist who has never had toothache. And depression is so weird that it makes life exceptionally difficult for the partner or carer of the afflicted individual. I was happily married, a professor with a fine job, and only wanted to kill myself – my wife found it somewhat intolerable. Writers have been much better at describing their own condition and Oyebode has referred to several, such as Styron and Mill. I would like to add to the list. Elizabeth Wurtzel, in her description of her depression in *Prozac Nation*, includes the claim that it has nothing to do with life and that she was among 'the walking, waking dead' (Wurtzell, 1995: p. 22). Tolstoy, in *My Confessions* (1882), described himself as healthy and happy yet suicidal – life had no meaning for him:

> 'The thought of self-destruction now came to me as naturally as thoughts of how to improve my life had come formerly ... and it was then that I, a man favoured by fortune, hid a cord from myself lest I should hang myself from the crosspiece of the partition in my room' (Part IV).

There is also Job from so long ago:

> 'Why is light given to those in misery, and life to the bitter in soul, to those who long for death that does not come, who search for it more than hidden treasure, who are filled with gladness and rejoice when they reach the grave.'

https://doi.org/10.1192/apt.9.4.265 Published online by Cambridge University Press