

**SOUNDING MADNESS: THE ETHICS OF LISTENING IN JANET FRAME'S *FACES
IN THE WATER***

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ABSTRACT

Sounding Madness: The Ethics of Listening in Janet Frame's Faces in the Water is a transdisciplinary sonic exploration of the historical, cultural, and theoretical concerns surrounding electroshock's (AKA electroconvulsive therapy or ECT) impact on memory, its controversial accusations of erasure and its current revival as a "miracle" (Peck 2) treatment for complex trauma (PTSD). My project employs "sound as a verb" (Voegelin 17) for voicing claims of "memory erasure" (Andre 6) by women ECT survivors that have been named "groundless" (Fink 17) by psychiatrists. To do so, I propose a sonic interpretation of Janet Frame's 1961 novel *Faces in the Water*, a fictional account of her twelve-year stay in New Zealand mental institutions and 200 electroshock treatments in the late 1940s-1950s, because it depicts a rich sonic landscape of *shock* (treatment as trauma) and "madness as a new kind of music" (77). Since Frame prioritizes sound as a literary device, I weave her voice within a larger historical sonic context, dating back to Victorian medical electricity, the soundscape of the asylum and the sounds of contemporary Mad activism. Utilizing sound art as a Research-Creation method that employs and embodies diverse theories of listening (from psychoanalytic to phenomenological), I aim to create a sonic *space* for "listening otherwise" (Levinas, Lispari, Voegelin, Todd) towards Mad dialogical and epistemological justice.

DEDICATION

In loving memory of my father, James Foisy, who passed away while I was writing this dissertation on September 5th, 2020. I am forever grateful for his offbeat wisdom and encouragement throughout my creative process.

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PREFACE

“(…) the violent orchestration of unreason that seemed like a new kind of music of curse and cry with the undertones of silence flowing through (…)” (Frame 77).

The fragmented layers of memory that I retrace in this project are both personal and political. They are transgenerational and bring me back to a place where I have no words, only sounds that trigger a sense of *déjà-vu*, a dreamscape I cannot fully understand. This project began as a conversation with my aunt, a psychiatric survivor, who received electroconvulsive therapy (ECT) in the early 1990s and told me one day on the phone that the procedure did not *erase the right memories*. Her words made me think about the family history that had been erased from our collective memory: suicide, domestic violence, abuse, incarceration, psychiatric confinement. The list goes on. The stories we have hidden in boxes in the attic, in sentences we can't finish. Listening to my aunt made me think about how I cannot remember my mother's voice, her suicide always in the background like a distant murmur. I never met my grandmother, who died young from cancer and at the hands of a violent husband. Another story buried. I was curious about what my aunt meant by the *right memories* and how any treatment could erase the *right memories* with any precision or ethical clearance. How could erasure be the cure? Erasing memories sounded unethical, in fact, impossible. The promise of a miraculous new life without any burdens or weight from the past seemed unlikely, unscientific, and unsound. How could any psychiatric treatment erase memories of abuse, poverty, violence with an electric current passing through the brain?

They didn't erase the right memories lingered in the back of my mind like a ghost haunting, reminding of past injustice in need of reparation, in need of attention. This

conversation happened the same year I first read Michel Foucault's poignant allusion that madness cannot speak¹ which made me pause. Whether my aunt was exaggerating about memory erasure or not, her complaint was not taken seriously by the experts responsible for her care, and so I was confided in. It was her diagnosis, not her word choice, which prevented her from being genuinely listened to, believed, and validated. The truth is, she never consented to ECT, and she doesn't remember signing any papers, reading any brochures, or watching any videos about the treatment. It was her brother who consented, and because she was a danger to herself and her family, she no longer had any agency in determining her future. This adds another layer about the ethics of listening in the psychiatric industrial complex²: Whose voices matter when it comes to deciding which treatment is best, which treatment will resolve the root cause? In my aunt's case, ECT did not resolve her problems; it only gave her new ones to deal with.

Searching for the *right* memories, I was eager to learn and listen to all of the stories I could find about the intersecting tensions of gender-based trauma, memory, and ECT by those who have survived the psychiatric industry. Building upon my previous sound-art based phenomenological research, *A Sound Memoir: Sound Collage for Listening to Suicide Survival Narratives* (2011) that developed theories of listening to soundscapes to restoratively work-

¹ Foucault, Michel. *History of Madness*. "In the midst of the serene world of mental illness, modern man no longer communicates with the madman: on one hand he is the man of reason, who delegates madness to the doctor, thereby authorizing no relation other than to the abstract universality of illness; and on the other is the man of madness, who only communicates with the other through the intermediary of a reason that is no less abstract (...). There is no common language: or rather it no longer exists (...). My intention was not to write the history of that language, but rather draw up the archaeology of that silence." (xxviii)

² The psychiatric industrial complex is "an industry that is involved in the creation of an "at-risk" population is also the creation of a market for technologies of classification, surveillance and intervention. Psy policing circulates to make citizens, delineate monsters, expel threats, project anxieties, do nation, and push profits all galvanized by the construction of "risk-factors" that are soaked in (bio)politics, statistically spun into populations, thrown into bodies and struck down with fear." (Holmes et al. 5-6)

through the trauma of my mother's suicide, I delved into memoirs and autobiographical accounts of ECT by women writers while working on a sound piece that could encapsulate my findings symbolically.

This is when I found Janet Frame's writing. I read her autobiographical trilogy *An Angel at my Table* and later her novels *Faces in the Water* and *Towards Another Summer*, and I found that her writing was sound-based and lyrically inflected, and that she was writing about her experience with ECT to re-member it (assembling information in a new, perhaps, *shocking* way) differently. Her voice was an electric current that ran through my body, connecting me to my past and possible futures in the present. She was my entry-point, teacher, and collaborator in this project. I worked to channel the energy in her novels that resonated with the generations of women in my family that had been psychiatrized against their will and whose voices were systemically silenced. She taught me how to listen to madness in a new way. As a sound artist and humanities scholar, I wonder, what can psychiatry learn from the arts when it comes to listening? How do sound artists relate to listening as a process: is it a core component of one's ethical capacity to receive the other compassionately and humbly? Salome Voegelin discusses how sound artists often create a world of possible futures for their listeners (Voegelin 34), and this seems quite ambitious and noble. How is listening part of one's artistic and ethical research process? Along this tangent, my work is grounded in a research-creation practice that finds itself listening and following questions that drive curiosity, passion and love. As Natalie Loveless eloquently says in her manifesto *Making Art at the End of the World*, we, as artist-researchers, must be guided by the "heartmind" (3) to expand the field of knowledge-making and world-making (39). We can no longer be solely guided by institutionally defined disciplines given the

existential quandaries and urgencies in equity we collectively face. At this time in history, our job is to allow:

ourselves to be drawn by our loves, our intensive and extensive curiosities attentive to what and whom we are driven to explore and examine the complex web of relations that inherit thereby that we might inhabit research questions ethically. (39)

My work is an act of love that is undisciplined and wild, it is research-creation guided by madness as methodology (Gale) and listening otherwise (Levinas, Lispari, Voegelin, Todd). I aim to create a space for audiences to explore their discomfort with what exists beyond the parameters of language and understanding, to engage with the discomfort of memory erasure and to imagine new ways of listening to distress.

This project is not about whether ECT is an effective treatment; it's about listening to madness when it cannot speak. It's about what is at stake in ignoring the subjective, in forgetting experiential knowledge and relying solely on measurable data within the evidence-based hierarchical knowledge regimes. The accounts of thousands of ECT survivors³, of whom the majority are women (Read et al. 263), will not be heard, read, or taken seriously as credible accounts of trauma, nor will their experience be counted as evidence-based knowledge. The women that I am most interested in attending to within this debate are those who received ECT without proper informed consent: women whose husbands signed consent forms on their behalf, women who were told there was something wrong with their personalities after they were abused, women who were convinced by doctors that there was no other way for them to continue

³ I refer to ECT-survivors as people who received ECT without proper consent and for whom it had a negative impact on their lives and cognitive functioning.

living without ECT. The woman I am particularly interested in is Janet Frame. Her book *Faces in the Water* was written in 1961 in the early days of the psychiatric survivor/ex-patient movement (the same year as Foucault's seminal text *Madness: the Invention of an Idea*). Frame was willingly institutionalized for over twelve years in New Zealand. Her writing predates the concept of "recovery" (grassroots self-help or mainstream definitions alike), her account is well ahead of its time in its embrace of madness as artistic methodology, sound composition, and writing practice. She writes as a form of resistance, a way to reclaim and re-member her experiences of shock within the asylum and to advocate for psychiatric patients to be listened to outside of diagnostic listening or pathologization. Frame writes about how madness is "a new kind of music" (77) that transcends paternalistic false harmony towards a radically practicing community that *listens otherwise*.

Madness as communicative limit-case echoes a deeper metaphorical wound: How is the Western psychiatric industrial complex meant to listen to the subjectivity of patients if it is based on biomedical and economic metrics that emphasize the "body-as-a-machine" (Loftus 214)? In response to this question, I engage with Frame's poetics of sound in *Faces in the Water* to explore the ethics of listening otherwise and to generate a way into madness as a new kind of music. My project is an interrogation of the power of sound, both intimate and public, asking how it can mobilize us to listen to voices that have been systematically ignored and erased from history.

Wrapped up in ideals about productivity and progress, ECT becomes an attractive solution when the mind, conceptualized as a computer instead of as a universe, is no longer concerned with consciousness. Memory erasure becomes a cure and listening to what is *beneath* the diagnostic symptoms is incidental. Foucault's provocation has more to do with listening than

speaking. Can psychiatrists listen to their patients ethically if they are searching for symptoms, trying to re-order a disordered narrative? Alternatively, do they listen more like a prosecutor looking for evidence to prove someone is guilty of a crime? Could they listen otherwise, from the place where madness speaks liberated? How can madness be a methodology for rethinking the ethics of listening versus the ethics of “curing” within psychiatry and the mental health industrial complex?

I also work through the concept of listening otherwise (Levians, Lispari, Voegelin, Todd) as an ethical gesture for re-membering history in the present. Paul Ricoeur in *Memory, History, and Forgetting* saw the ethics of memory as a form of listening to an in-transmissible and traumatic past, as engagement with voices obscured by history’s master narratives. Similarly, Jacques Derrida in *Specters of Marx* developed the method of hauntology⁴ to think through the ways a wounded and marginalized past haunts the present as a silence that speaks. Both theorists centered listening to silence, or what has been silenced through dominant representations, as an ethical turn necessary for history to become praxis for re-authoring towards justice in the living present. Being heard, listened to, and ultimately understood is what the psychiatric

⁴ Hauntology combines the words “haunt” with “ontology”. With this playful philosophical term, Derrida was referring to how we need to attend to the “ghosts” of unrecorded or erased histories, the stories of injustices that have been swept under the rug or denied by systems of institutional knowledge-power. We need to learn how to live with those stories through allowing ourselves to be haunted on an ontological level, and shift our actions accordingly towards justice. He says: “The time of ‘learning to live,’ a time without a tutelary present, would amount to this, to which this exordium is leading us: to learn to live with ghosts, in the upkeep, the conversation, the company, or the companionship, in the commerce without commerce of ghosts. To live otherwise and better. No, not better, but more justly. But with them.” (Derrida *Specters of Marx* xviii) In *Specters of Marx*, Derrida suggests that the present may not be able to teach us how to live ethically or justly with injustice. Instead, we must learn justice from the past as it is repeated in the present and towards the future, from the stuttering of those who came before and who are no longer—from welcoming ghosts and their possibility of living otherwise. The Derridian ghost is related to the Lévinasian Other, in that it cannot be assimilated or known by the subject, yet, ethically speaking, it must be listened to and attended to with respect to its alterity. Derrida urges that one must “speak to it” beyond the categories and empirical knowledge that assume to know it, to learn from the ghost how “justice carries life beyond present life or its actual being-there, its empirical or ontological actuality: not toward death but toward a living-on (sur-vie) a survival whose possibility in advance comes to dis-join or dis-adjust the identity of the living present as well as any effectivity” (*Spectres of Marx* xx).

survivor/service-user movement, geared towards validating a patient's experiences and analysis, seeks to accomplish (Burstow 16, Andre 6). While listening to patients' history is central to psychiatric intervention, ECT's "memory erasure" (Andre 6) contradicts that goal. The psychiatrist is meant to be a compassionate and skilled listener, who can guide patients through suffering towards articulation, however, ECT's unrefined, indiscriminate erasure may not always help patients make sense of their lives.

History matters, yet psychiatric survivor history and analysis is obscured or rendered illegitimate within mainstream psychiatric institutions, knowledge production and engagement practices. Their voices are not listened to as trustworthy testimonies despite the turn towards patient engagement in the mental health industry. When I was a volunteer archivist at the Psychiatric Survivor Archive of Toronto (PSAT), I genuinely felt for the first time in my life like I had found a language that made sense. I was able to resist psychiatric labelling and reclaim madness as a source of power and critique. I grew to love madness and to hear it as a new kind of music that challenged conventional harmony and made space for my rhythm. But madness cannot speak within institutions: it is regulated, pathologized, considered to be in need of cure or treatment. I am concerned about the co-optation, and subsequent depoliticizing of ideas and practices that emerged through the survivor/Mad Pride liberation movement by evidence-based psychiatry who use patient stories as fuel to justify their practice. ECT "recovery narratives" (Woods, Hart and Spandler) are deployed to erase the dissenting voices of critique who refuse to sell something that didn't help them and who speak to the broader socio-economic structures that keep people down.

Today, patient engagement is gaining more and more momentum as it becomes enshrined in legislation, best practice and quality improvement healthcare guidelines⁵. Now patients' lived experience and testimonies are brought in strategically, which might seem like progress, but it has a dark side, one that continues to obscure patient critique and analysis with agendas that are managed by institutions. These engagement efforts to legitimize the "voice of lived experience" operate under assumed transparency, neutrality, and compulsory positivity. This is a practice akin to the cure story of miracle erasure. It silences dissent: the voice that is angry, tired, and unwell that refuses to be managed by neutral benevolence, is slowly being drowned out in the false harmony of patient engagement and recovery narratives orchestrated by institutions. Could ethical engagement be a commitment to critique as an act of love, to honour all the knowledge that doesn't make it into mainstream evidence, and to admit that representation fetishizes authenticity for the sake of reproducing the status quo? How can we listen without trying to know madness with certainty, but welcome it as a new kind of music? This new kind of music offers the possibility of a world that dissolves hierarchical systems of truth and meaning.

My project seeks to dissolve hierarchies of knowledge-production and center madness as a language, methodology, and epistemology worth listening to. By co-creating a sonic landscape with Janet Frame's novel *Faces in the Water* and the psychiatric survivor movement, this project illuminates the power of madness as a new kind of music. This new kind of music breaks harmonic form and convention to re-member (assembling information in a new, perhaps, *shocking* way) voices erased from history, and it offers the opportunity for us to listen *otherwise*

INTRODUCTION

We all see the faces in the water. We smother our memory of them, even our belief in their reality, and become calm people of the world; or we can neither forget nor help them. Sometimes by a trick of circumstance or dream or in a hostile neighbourhood of light, we see our own face. (Frame 150)

Sounding Madness: The Ethics of Listening in Janet Frame's Faces in the Water is a transdisciplinary sonic exploration of the historical, cultural, and theoretical concerns surrounding electroshock's (AKA electroconvulsive therapy or ECT) impact on memory, its controversial accusations of erasure and its current revival as a "miracle" (Peck 2) treatment for trauma (PTSD). Working with Janet Frame's 1961 autobiographical novel about her experience with over 200 coercive ECT treatments, *Faces in the Water*, I explore the ethics of listening otherwise and generate a way into madness as "a new kind of music" (Frame 77). Ultimately, this is a study on the ethics of listening to unsound sound, on welcoming madness as sound to be heard without the need to confine it to meaning or understanding. This is also a study on the contradictions of evidence-based psychiatry and whether such practices can be ethical (Gupta 2). The promise of erasing "bad" memories using invasive interventions such as ECT has gained prominence within popular scientific literature (Maguire et al; Griffiths and O'Neil Kerr; Rose et al.; Delistraty). But what are "bad" memories? Should they be erased? How, instead, could we care for our memories, honour them, and heal with them?

Utilizing sound art as a research method that employs and embodies diverse theories of listening, I aim to create a sonic *space* where people can listen to silenced, disenfranchised

narratives related to ECT's memories of erasure. I focus on women who received involuntary and coercive ECT and who wrote about their experiences of memory erasure in the form of memoirs and autobiographical fiction. Namely, my work engages with Janet Frame's account of ECT in the novel *Faces in the Water* (1961) that re-members (assembles in a new way) her shock experience paying specific attention to sounds within the asylum and the voices of the patients around her, as well as the role of listening for survival. I weave Frame's voice within a larger historical sonic context, dating back to Victorian medical electricity, the soundscape of the asylum and the sounds of contemporary Mad activism.

My project employs "sound as a verb" (Voegelin 17) for voicing the psychiatric limitations of care and for legitimizing the trauma that has been named "groundless" (Fink 17) by ECT supporters and clinical administrators. To do so, I propose a sonic interpretation of Janet Frame's 1961 novel *Faces in the Water*, a fictional account of her twelve-year stay in New Zealand mental institutions and 200 electroshock treatments in the late 1940s-1950s, because, through sound metaphors, it depicts a rich sonic landscape of *shock* (electroshock as treatment and as trauma) from a gendered perspective that resounds in a silent art form as an epistemological embodiment. Frame uses sound metaphors to illustrate the emotional extent of the shock experience and to provoke readers to "listen to" the disenfranchised, forgotten, and silenced mad women in her novel. My sound pieces are interpretations that I hope will illuminate the protagonist's personal crisis, depicted by Frame as a sense of existential homelessness, into a new modality/interface whereby listening creates a world where madness can inhabit and speak. My dissertation and sound art are not advocating for art as therapy, but rather as a disruption of an epistemological hegemony and a reclamation of the acoustemology of the asylum that is often omitted from history and academic writing on madness (MacKinnon 77).

My work interrogates the intersections of voice, trauma and sound, and considers how Frame uses sound (and songs) to work through a type of suffering that no one can recognize or hear (both in the text and in society). Speaking to ECT's clinical goal of "restructuring the brain" (Fink 23), I consider how to restructure recursive literary representations and metaphors of female "madness", "otherness" and "homelessness" through the shock of sound collage to facilitate a critical, ethical and compassionate form of listening to engendered mental distress.

Theories of listening span a wide range of disciplines, from phenomenology to psychiatry, as "listening has become an increasingly popular subject of study" (Carlyle and Lane 9). As a sound artist, I think of listening as a practice that can reveal a parallel reality, one that lies below or inside of that which is immediately accessible. The immersive nature of listening can place the listener at the centre of a sound piece, creating an intimate space and connection to the invisible, to what haunts. David Toop calls sound: "a ghost, a presence whose location in space is ambiguous and whose existence in time is transitory" (xv). The intangibility of sound is uncanny—a phenomenal presence both in the head, at its point of source and all around—so never entirely distinct from auditory hallucinations. I conceptualize listening as a method of engagement with ephemeral, incoherent, and ungraspable traces of experience: a perfect vehicle for working with the limit-cases of "memory erasure," madness, and trauma.

Listening is closely tied to ethics and social justice, a practice of negotiation and disruption. I relate to Emmanuel Levinas' concept of listening as a gesture toward the Other, as a way of attending to their incomprehensible difference without the need to contain their speech in "fixed" meaning (65). The fluidity of listening, according to Levinas, would afford a communicative exchange that resists hermeneutic dominance. Listening, in this sense, makes possible ethical engagements with marginalized individuals who are silenced within the confines

of biomedical psychiatric institutions and language—it becomes a way to encourage their speech to resound in meaningful ways, toward building narrative community outside of psychiatric labels and management.

To think through the “ethics of listening” (Todd, Levinas, Voegelin, Lispari) toward limit- cases such as: “memory erasure” (Andre 6), madness, and trauma—what it means to welcome speech that cannot be “understood” in a linear narrative fashion, I propose to listen to the stutters, murmurs and silent articulations of these experiences in a literary work on electroshock that has been forgotten by the canon: Janet Frame’s *Faces in the Water*. She is the only writer in the ECT canon to prioritize sound as a literary device, and I wanted to experiment with envisioning her novel as a compositional score in my sound art. Thus my project employs “sound as a verb” (Voegelin 17) and “sounding” (Henrique) for voicing the psychiatric limitations that create the condition of what Michel Foucault suggest as, madness cannot speak (*History of Madness* xxviii) and moving beyond those limitations into the possibilities of listening otherwise (Levinas, Lispari, Voegelin, Todd). Madness cannot speak due to structural violence and epistemological hegemony that invalidates mad voices and knowledge production.

Engaging with a hauntological silence that speaks, unlike most authors in the electroshock canon, Frame uses sound metaphors to situate the protagonist, ontologically and politically, within the anxious landscape of society and the asylum. The novel begins with Istina Mavet, the protagonist, describing an apocalyptic fantasy using soundscape. She listens to the city as an outsider, alienated and afraid. The protagonist imagines how social norms would dissolve into “hysteria” under the stress of a doomsday natural disaster. Citizens would become disoriented and confused—resembling how Istina feels panicked and unsure within the mundane everyday of city life: “the streets throng, resounding with people who panic, covering the

scissors, sucking the poison from a wound they can't find (...). But the shop windows were speaking to me (...) I was not yet civilized, I traded my safety for the glass beads" (5). Although Frame is not overtly describing the chaotic sounds of the city, she infers a soundscape of anxiety and hallucination, one that questions the borders of real versus imaginary sounds. This scene foreshadows her later diagnosis of schizophrenia, which by the end of the novel turns out to be false. This misdiagnosis reflects a mishearing. The social world and the institutional world of the asylum do not hear Istina as a subject or agent. Instead, they hear symptoms of schizophrenia. They hear a psychiatric label when they should be hearing and attending to her distress. Frame's soundscapes allude to the regulatory function of psychiatric language and listening: when the patient speaks, the doctor hears biological symptoms intertwined with a story. They hear the Diagnostic Statistical Manual (DSM), the categories of illness, embedded in the patient's speech. But they do not hear the patient. By emphasizing sound, Frame calls attention to the lack of listening, as an ethical relationship, within psychiatric care.

There are four major soundscapes depicted in Frame's novel: cityscape, asylum, nature, and internal world/voice. Each represents a built or organic environment entrenched with memory and trauma. She attentively describes the sounds of each environment to create a space for madness to speak beyond the limits of psychiatric institutional language. My sound pieces are soundings that I hope will illuminate the protagonist's crisis, depicted by Frame as a sense of existential homelessness, into a new modality/interface whereby listening creates a world where madness can inhabit and speak otherwise.

Overview and Structure of Chapters

Chapter 1: Histories of Erasure: ECT Medical History and Survivor Narratives

After a preliminary definition in chapter one, I reflect upon electroshock therapy's genealogy as medical electricity, its modern manifestation as electroconvulsive therapy (or ECT), and its newly refined incarnation as transcranial magnetic brain stimulation or cognitive enhancement. From shock to stimulation, I outline the discourse of electricity as a regenerative source of life, charged dually with curative and destructive power, which fascinated ancient and modern natural philosophers, physicians, and scientists, as well as poets, writers, biopsychiatry and artists. The electrical "boom" in medicine reached its pinnacle during the Victorian era, which produced an increase in devices meant for channeling electricity in and through the body. My goal is to remember electroshock's early therapeutic and experimental beginnings, which predate its present-day incarnation, to work through medical electricity's promise to stimulate and invigorate "dead" energy within the human body and re-balance its flow.

I juxtapose such promise with the modern discursive "miracle" of electroshock. Electroshock's biomedical framing as a "miracle" is linked to Victorian imaginations of electricity's power to revive the dead, cure the mute, and jolt the lethargic into productivity. A discursive analysis of ECT's framing as a "miracle" reveals the ideological underpinnings of biopsychiatry technology, and "evangelized" claim to "cure" the mind of suffering, sometimes in unethical or harmful ways. However, concepts of "miracle" within biological psychiatry, a paradigm that stresses the scientifically verifiable and "objective," seem contradictory. Religious language is heavily embedded within the biomedical promise of "miracle treatments," and I question the ethical costs of such affirmations. Similar language is used by the activist community, who state "Memory is Sacred" (Weitz, Burstow) in response to ECT's controversial

effects on memory. In the context of trauma, naming a medical procedure “miracle,” or elevating memory to a level of sacredness, poses questions about what recovery can mean, ethically, and about what the role of memory is in the recovery process. Many PTSD survivors, for example, desire to forget their memories (or rather how their memories are narrated) to work-through their distress and relearn how to trust (Freud 156). Thus, this chapter will end by weighing the ethical contours of memory and forgetting alongside ECT’s accusations of “memory erasure.” I will examine how the psychiatric survivor movement and the medical community have made their claims of miracle/erasure, and explore how the dichotomy manifests discursively in the context of narrating trauma in life writing (fiction/non-fiction) on ECT. I will engage with the theoretical work of Leigh Gilmore and Paul Ricoeur (among others) to tease out the affordances and contradictions of remembering a life under erasure through autobiographical practices, which I then expand upon in chapter three, where I spend more time analyzing Frame’s *Faces in the Water*.

Chapter 2: *Madness Cannot Speak and the Ethics of Listening Otherwise in Psychiatry*

In chapter two, I unpack the concept of listening within psychiatry from contrasting ethical and socio-political perspectives. I begin by centering madness as epistemology and methodology. I engage with mad studies theory and critical analysis of listening practices within psychiatry and patient engagement. Mad epistemology is grounded in the history of psychiatric survivor and service user analysis and research and intervenes on this new era of patient engagement⁶

¹ Patient Engagement within the Mental Health and Addiction formally began in 2010 with the creation of the Canadian Mental Health Commission in addition to the *Excellent Care for All Act*. In 2012, *Changing Directions, Changing Lives: The Mental Health Strategy of Canada* recommended the inclusion and active involvement of persons living with mental health or addictions in areas such as program design, planning, delivery, evaluation and monitoring, policy research, leadership and development. In Ontario, since 2010 we have seen legislation that mandates “patient engagement” in system-level work. In the 10 year Mental Health Strategy developed by the

initiatives that are, in fact, new forms of institutionalization (Johannesen, Voronka, Costa). I argue that these new forms of institutionalization operate under the guise of empowerment and system change but fundamentally sustain the asylum's specter of madness cannot speak. Specifically, this brand of mandatory patient engagement has generated a new genre of life writing and storytelling, coined by Angela Woods, Akiko Hart, and Helen Spandler as "recovery narratives," which are instigated and controlled by institutions to promote various treatments or programs. Another side to patient engagement is how engaged-patients are becoming leaders in the system without any knowledge or grounding in the history of psychiatric survivors or Mad activism (Voronka, Johannesen, Costa). Uncritical and opaquely positive, these narratives espouse the language of *miracle* and contribute to the systematic erasure of psychiatric survivor/service users and mad knowledge and critical analysis. I think we should critique the overemphasis on voice and speech, and consider what we might learn from listening. I suggest this phenomenon is rooted in psychiatry's inability to listen beyond time-based, cost-effective diagnostics, and/or normative surveillance. To listen *otherwise* (Levinas, Lispari, Voegelin, Todd), beyond the conquest to *know* the patient via the psychiatric interview that defines by diagnosis and measures recovery by a checklist of alleviated symptoms, would mean to welcome the patient as ultimately, an unknowable subject, unmeasurable and undefinable. This seems contrary to the goals of psychiatry that seeks to "find" (Mohl 2) the patient, and solve their problems with the promise of biomedical science (same can be said for solution-based crisis intervention). Listening otherwise does not aim to locate the patient within a particular identity,

Minister's Advisory Group entitled "Respect, Recovery, Resilience: Recommendations from Ontario's Mental Health and Addiction Strategy" and in the Patients First: An Action Plan for Health Care there is a prioritization of patient experience in creating a system that will best serve them. However, these institutionalized mechanisms for bringing in the patient perspective in healthcare have its limitations and silences a lot of the critical analysis that the psychiatric and disability justice movements were centering back in the 1970s, 1980s and 1990s.

nor does it aim to fix what might appear broken, rather it welcomes the patient into a relationship of co-creation, where meaning-making is ongoing, horizontal, and process-based instead of goal-oriented, hierarchical and finite. This form of listening comes from dialogic philosophy (Levinas, Lispari, Voegelin, Todd) and it is the foundation of all ethical relationships. I end the chapter by tying these ideas back to ECT as a treatment that is cost-effective, yet hinders patients' memory, and by extension, their creative self-expression, voice, and sense of self. If a patient's memories are erased, how can they articulate their stories of distress to make meaning out of their lives, or how can they participate in the world as creative and productive individuals? Listening in a solution-focused biomedical way is what motivates the prescription of ECT as the *only way* to solve depression that is *treatment-resistant*, and it hinders psychiatrists' ability to hold space for the patient's complex consciousness and the non-biomedical reasons for their distress. Listening otherwise may not be able to solve patients' symptoms, but it is not meant to be positioned as a solution. This form of listening seeks only to hold space for "Otherness" (Levinas, Voegelin, Lispari Todd) to be received non-violently.

Chapter 3: *Janet Frame's Life Writing and Faces in the Water*

In chapter 3, the heart of my dissertation, I focus on Janet Frame's (1961) novel *Faces in the Water* that re-members her twelve-year stay in New Zealand asylums (1945-1957), where she received electroshock therapy (ECT) against her consent as forced treatment. Before I delve into the novel, I highlight some prominent themes from Frame's life writing (1982, 1984, 1985) related to theories of listening, poetic identity, and the creation of selfhood for a woman of her generation and social class. Her life writing also outlines her creative process for writing *Faces in the Water* (1961) and the ethical role of listening to the voices of those she met during her

time in the asylum. Although Frame may not have publicly identified as a “psychiatric survivor” per se, she did view her writing as political. Her writing, including its phenomenological descriptions of sound, transmits what the asylum felt like and sounded-like from the inside—but it also resounds with psychiatric survivors’ voices (her own and those around her) and their need to be heard compassionately and legitimately within the world at large.

The novel profiles electroshock as “a new way and fashionable way of quieting people” (9). *Faces in the Water* symbolizes psychiatric patients as lives under erasure, muted voices, and distorted faces—and, more profoundly, the social responsibility to attend to the patients, trapped in the monumental silence of asylums. With the text set in 1945, Frame’s experiences of mental health issues were at a time when there was no such thing as “recovery” or “wellness” for someone with a psychiatric label. As she writes, there was “no voluntary admission; we were all insane under the Mental Defectives Act, 1928” (36). As I discussed in chapter one, during the asylum era, people who were diagnosed with a psychiatric disorder (or in some cases, “defect”) were consequently stripped of their civic voice, freedoms, and/or rights. They were not allowed to have their own bank accounts, have jobs, or participate in society (36). Asylums functioned as prisons for the unwanted, the poor, and *unproductive* members of society, who were seen as a diseased population beyond hope. To relieve the burden they put on their families, state-run asylums were set up to be places of confinement, structure, and order, for them to spend the rest of their days, safely tucked away from view. The rationale was to lock the unwanted away to preserve moral hygiene (Foucault, *Madness the Invention of an Idea* 116-117).

To navigate the silencing effects of institutionalization, Frame attempts to communicate through sound-metaphors and images the “unspeakable suffering” (Kadar 7) of fellow asylum inmates and the incredible responsibility to attend and listen. The incommunicability of madness,

wherein others cannot understand what one is experiencing, fosters feelings of profound isolation and alienation— one of the central themes of the book. Listening becomes an ethical gesture towards the alterity of the Other that is irrecoverable through language. Coincidentally, the novel was published the same year as Michel Foucault's *Madness the Invention of an Idea* (1961) at the beginning of the psychiatric survivor movement, and in many ways, it embodies that concept, yet it also presents readers with a theory of listening to madness *otherwise* as it centers on “sound as a verb” (Voegelin 17). “Sound as a verb” denotes a call to action that suggests sound as the invisible layer of the world that shows its relationships, actions, and dynamics through an engagement with the ephemeral, a performativity, and responsibility of “doing” (Voegelin 17). Writing sound, as textual phonography, parallels field recording that captures the acoustic ecology of built and organic environments. Frame's fiction urges readers to listen to the voices of the voiceless, forgotten behind institutional walls, and lost to treatments that robbed them of the ability to care for their memories. Her fiction prioritizes sound as a literary device, almost as a field recording of what it felt like to be institutionalized, given ECT as forced treatment and never listened to as a being but as a defective object to be fixed.

I demonstrate how Janet Frame's novel is an example of the tensions between dialogic and diagnostic listening. Ultimately, the way in which she depicts the various soundscapes inside/outside the asylum embodies the concept of listening otherwise—thus allowing madness to speak. I outline the context in which the novel was written to explore how the 1960s psychiatric survivor and later 1980-1990s mad movement unfolded during the time the novel was published. This was the first time in history that patients were speaking out against not being listened to and being mistreated by a system that saw them as hopeless burdens. They produced testimony in many different genres to reclaim madness as an integral part of their unique

contributions to the world, their creative self-expression, and their survival of trauma. Such activism has made the case for “lived experience” and “patient engagement” within the mental health system for quality improvement. However, as I outlined in Chapter 2 and the Postscript, these institutional gestures to include patient voices are co-opted and immersed in “ethical domination” (Voronka 33).

I return again to supplementary life writing to better understand Frame's broader use of music and soundscapes beyond the novel. Frame's fascination with music and soundscapes goes beyond her novel, as described in her autobiographical trilogy (1982, 1984, 1985) *An Angel at my Table*. Song is her introduction to poetry, symphony and orchestral music as a transcendental mechanism for her to experience and understand her inner emotions in a new way (to flow with her inner life, instead of trying to control it with strict goal-oriented voices). It is also a way for her to relax outside of the mundane anxiety of Teachers' College—a place that did not feed her thirst for imagination and poetic conjecture. In the foreword to *An Angel at my Table*, New Zealand screenwriter and filmmaker Jane Campion, who adapted the book into a movie, says that Frame's voice is so natural, that it is as if it resisted commonplace patriarchal notions that women were meant to be seen and not heard: “She has achieved that supremely difficult task of finding a voice so natural it feels as if it were not written but always was” (*An Angel at my Table* xi). Campion describes the healing effect of reading Frame as a young teenage girl, “her dark, eloquent song captured my heart” (x) which resulted in Campion finding her voice through Frame: “it was this inner world of gorgeously imagined riches that Janet Frame affirmed in Daphne, but also in me, and quite possibly in all sensitive teenage girls. We had been given a voice, poetic, powerful, and fated—a beautiful, mysterious song of the soul. I read the book at fourteen when my life felt like torture” (x). A transgenerational healing occurs through

autobiographical poetics and sharing one's voice in artistic representations that preserve memories as they transform them.

I explore the complex relationship between Frame's development of voice and agency, her misdiagnosis of schizophrenia, and how her creative process of listening and writing leads towards the compassionate integration of madness within selfhood. I call this process, in Frame's case as in the women who survived ECT's memory erasure and chose to represent it through fragmented autobiography, "re-membering erasure". Erasure is thus subverted from being a site of emptiness to being a site full of creative and radical potential for transformation.

Chapter 4: *Sounding Madness: My sound art in response to Faces in the Water*

In chapter four, I describe the sound pieces that I made in response to my dissertation research and the novel *Faces in the Water*. I focus on what I have learned from Janet Frame about listening as resistance within the asylum soundscape while engaging with the theory of sounding (sound as a verb) defined as a transitory embodiment in time that serves to draw attention to a different object of inquiry, beyond representation, towards process. I engage with the psychiatric survivor history of ECT and women's memory erasure from an ethical and relational perspective. In this chapter, I discuss the components of the three sound art pieces I composed and their methodologies, which include "real-world music", "soundscapes", "sound collage" as well as "madness as methodology" (Gale). I also employ theoretical concepts such as "listening otherwise" (Levinas, Lispari, Voegelin, Todd) and "madness as a new kind of music" to guide my compositional methods. The three sound pieces that I made embody the theories of listening outlined in my dissertation. Each piece holds particular resonance with Janet Frame's writing and the ethics of listening otherwise.

The first piece, “Faces in the Water”, deals with concepts of self-reflexivity within psychiatric listening and asks: What can psychiatric listening learn from sound-art? In this piece, I focus on the speaker’s reflection on the thin line between self/other. I recorded my voice reading passages of the novel. Conjuring Istina’s voice as it spoke to my own lived experience of the psychiatric system, I was hoping to reflect on how Istina’s voice resonates within my own and within generations of women who have undergone coercive ECT and have claimed “memory erasure”. Istina’s voice is a reflection of Frame’s voice and a reflection of my voice reflecting upon the voices of others. The act of recording defies erasure, subverts it. Yet the process remains unfinished and full of incomplete meaning; it requires an audience to engage with it and to reflect upon it. Such reflexive and inter-subjective techniques have been integrated into sound art practices where the “epistemological process in which interconnectivity is indeterminate and resistant to synergy” (Garoian 92). I am liberating sound from the musical score, just as I am liberating madness from psychiatric pathologization.

One of the major features of the second piece, “Season of Peril”, is how it captures the many rallies and protests during my academic research thus far, where I had the chance to record various real-world soundscapes of psychiatric-survivor and Mad voices. Intersections between Mad studies/survivor epistemology and sound studies emerge to critique the biomedical psychiatric paradigm and regimes of truth. The way in which ECT survivors have used their voices to speak out and resist institutions that have claimed their experiences to be invalid, embody the principles of “sound as a verb” (Voegelin 17). I want to listen to the “music” that emerges from the everyday sounds of lived experience, mad studies, and the psychiatric survivor movement (that is now more of a subtle, insidious occupation of institutions, whereby people

with lived experience of mental health/addictions issues are working from within the walls of the institution). I seek to uncouple music from formal harmony, to foster listening otherwise.

In the third piece, “Madness as a New Kind of Music” I collaborate with Mad-identified musicians to compose using madness as methodology (Gale). This piece reflects on power, voice, and memory, much like the other pieces, but in a more chaotic and symbolic way. I worked with two mad musicians to create an electrical soundscape that would bring to life the sonic metaphors in the novel: namely the ones where Istina is witnessing a surge in power in the patients around her, and how she stays “safe” by hiding and listening from a linen closet (Frame 26). Sound as intimate power and sound as social power collide in this piece, which is a sort of accumulation of the two previous pieces I discussed: “Faces in the Water” and “Season of Peril”, “Madness as a New Kind of Music” creates a context for “sound as a verb” (Voegelin 17) to subvert the epistemological underpinnings of madness cannot speak. I hope it can bring listeners closer to the symbolic abyss, to confront their fear and misunderstanding of madness. But more than that, I hope to create a context for questioning power on multiple layers, from the electrical, sonic, subjective, and social. Sounding sections of the novel where patients subvert the institutional power of the asylum through their bodies and voices in a new kind of music that speaks of transcendence and freedom, I want to showcase how these actions are productive and important for navigating this history of memory erasure. The goal is to restore madness as a viable mode of expression, as a way of knowing outside of psychiatric pathologizations and to re-member its erasure as epistemological power.

Conclusion

Research-Creation offers transformative and innovative ways of responding to ethical questions that cannot be solved by one discipline alone (Loveless 3). I offer a sonic intervention to consider the role of listening in liberating madness and validating it as a resonant source of knowledge, experience, and critique. I further problematize the contemporary ECT-canon “recovery narratives” (Woods, Hart and Spandler) deployed by institutions because the “journey of recovery” in these narratives is plotted with the intent to erase madness as a viable and livable state of being.

By sounding Frame’s autobiographical novel as a score for re-imagining what madness could sound like outside of the medical model, popular culture, and dominant historical narratives that frame it as lack, illness or danger in need of policing or containment; I am sounding hauntological connections between the psychiatric survivor history, Mad movement and our current “patient engagement” landscape to subvert overt/covert forms of memory erasure.

I consider how the grain of Janet Frame’s voice be re-covered, excavated, historicized and incorporated into current ECT medical discursive practices and knowledge-production. I dissolve hierarchies of knowledge-production to trouble what counts as evidence in research praxis by centering madness as a language, methodology, and epistemology worth listening to. My sound-based analysis and creation provokes Health Humanities, Mad Studies, Sound Studies, Life Writing to doubt their borders, to cross-pollinate and generate new possibilities for knowledge-making outside of a hierarchical or institutional legacy.

CHAPTER1: Histories of Erasure: ECT Medical History and Survivor Narratives

“Shock doesn’t make you forget things; it makes you never have known them.

After shock, the memories no longer exist” (Andre 6).

There is no longer any validity to the fear that electroshock will erase memory or make the patient unable to recall her life’s important events or recognize family members or return to work (...) that fear is groundless. (Fink 14)

Electroshock therapy (AKA electroconvulsive therapy) has a long and complex history, obfuscated by its serious impact on memory, and thus has been stigmatized and silenced as a contradictory form of care that plagues psychiatry’s past. This silence obscures the contemporary usage of electroshock—a practice most people believe to be a relic of the asylum era. This treatment has been rebranded as brain stimulation on the cutting edge of cost-effective treatments, part of a neoliberal “recovery narrative,” (Woods, Hart and Spandler) which aims to destigmatize psychiatric treatments that have gained criticism from former patients, service-users, and mad people as well as human rights advocacy groups. While downplaying the first-person testimonies of memory erasure, as well as service-user and mad people’s research that spans over 60 years, the cultural amnesia surrounding electroshock mirrors central criticisms of its controversial “memory erasure” (Andre 6), non-consensual misuse, and traumatic side-effects. As this controversial treatment makes a “quiet comeback” (Dukakis and Tye 25) in psychiatric care, now reborn as “a wonderful treatment,” (Dukakis and Tye 15) its history as “memory erasure” (Andre 6) is forgotten or, worse, de-legitimized as exaggerated pulp, or gothic horror (Endler 65, Fink 14). In 1982, critical psychiatrist Morris Fraser described how the idea

that ECT was making a comeback was inaccurate: “ECT has never been ‘in’ fashion or ‘out.’” (Fraser 2). Yet since then, medical journalists (Tye 45) have made the claim ECT has resurged, newly revamped, as a “miracle cure” for severe “treatment-resistant” depression (Peck 20). In relation to patient testimony, either claiming the treatment saved them from the torments of suicidal-thoughts or damaged their cognition to the point where they can no longer function independently in society, Morris Fraser says that neither side of the debate is accurate: “The trouble is that these criticisms do only rely on part-truths” (2).

The dichotomy between miracle/erasure is surely an artificial one, but the memories of all who undergo ECT need to be listened to, regardless of their position within this dichotomy. The “trouble,” to counter Morris Fraser, is with a search for accuracy within the autobiographical. This is especially troubling when the autobiographical is weighted by a biomedical promise of universal objectivity and truth. What weighs in as truth, what counts as legitimate knowledge within the biomedical, clinical “evidence-based” system, is often influenced by an industry and professional body of knowledge. Within the hierarchy of knowledge, “scientific purity,” untainted by subjectivity, is of the highest esteem. Michel Foucault’s concept of power-knowledge is useful in acknowledging how knowledge is never neutral and how it functions within an economy of power. Foucault claimed that “it is not possible for power to be exercised without knowledge, and it is impossible for knowledge not to engender power” (Foucault, *Discipline and Punish* 52). Knowledge is constructed through power and is thus biased with the intention to *yield* power. The search for authenticity and accuracy within “evidence-based” psychiatry is part of the problem; it does not align with ethical forms of listening otherwise which require us to doubt what we think we know about the Other. Knowing the Other is to have power over them, and it prevents us from listening with an open-ended perspective. As Daniel

Pettman says, “The very act of listening requires a different mind-set and practice from our usual design-related solutions to the world’s accelerating problems” (94). Being able to attend to the Other through gestures of listening is an act of ethical solidarity.

One of the greatest gifts in Frame’s writing is a troubled authenticity, a subject that is unsure of what it knows beyond an embodied sense of being troubled without discernible reason. She communicates trauma with a sonic slant, with madness as a new kind of music that is capable of listening to centuries of unknowable pain. Trauma is always/already an impossible narrative to validate or verify in terms of “veracity”, as Leigh Gilmore states:

(...) trauma cannot be spoken of or written about in any mode other than the literal. To do so risks negating it. In another view, trauma it is claimed, does not exist until it can be articulated and heard by a sympathetic listener. This view swings to the other extreme claim that without language experience is nothing. (...) Thus, the joint project of representing the self and representing trauma reveals their structural entanglement with law as a metaphor for authority and veracity, and as a framework within which testimonial speech is heard. (*The Limits of Autobiography* 7)

The non-representational aspect of trauma counters evidence-based psychiatry that seeks to empirically diagnose, treat, and resolve a knowable “mental disorder.” Listening to trauma requires an openness that is counterintuitive to a psychiatrists’ epistemological training that names cause and effect without much room for transcendental wonder or alternate views of consciousness. As Mark Wolynn says about transgenerational trauma and memory: “A well-documented feature of trauma, one familiar to many, is our inability to articulate what happens to us. Not only do we lose our words, but something happens with our memory as well” (15).

Bessel van der Kolk, a Dutch psychiatrist, has acknowledged this gap between empirical and experiential knowledge in his studies on PTSD. When discussing how he works to treat trauma through theater and performing arts, he says, “it is surprising how little research exists on how collective ceremonies affect the mind and brain and how they might prevent or alleviate trauma” (336). Van der Kolk’s work unveils a plethora of non-invasive evidence-based treatments for trauma, from EMDR to Neurofeedback, acknowledging how chronic abuse and neglect in childhood interfere with the proper sensory-integration systems. In spite of the fact that many of these treatments have existed since the 1950s, they have only risen to relative prominence in the 21st century (317). I explore the collision of trauma and ECT in chapter 3, when I discuss Janet Frame’s autobiographical accounts of early childhood abuse and neglect in addition to living in poverty. Poetry and music were essential for her to express the deep-seated trauma of her past, yet she was given forced-confinement in an asylum and ECT instead of other trauma-informed modalities.

A trauma-informed approach to psychiatry would recognize the non-representational and experiential evidence of trauma—how it is a silence that speaks that haunts one’s subjectivity and context. Especially when it comes to gender-based violence and trauma, how does evidence-based psychiatry listen to trauma ethically and engage women-identified patients in its scope? Thinking through how women-identified patients are more likely to be diagnosed with complex trauma and given ECT against their will (Read et al. 263) and how is ECT now framed as a cure for PTSD? Denise E. Eliot defines trauma-informed services as able to integrate an intersectional lens of oppression and the social determinants of health (464). The training manual for *Reduction of Seclusion and Restraint* by the National Association of State Mental Health Program, reports that 90% of people who screened positive for severe mental illness (schizophrenia, psychotic

depression, bipolar depression, etc.) have experienced trauma. Therefore, having a trauma-informed approach is essential for working with the complexities of people's mental health to ensure that their lived experience of victimization and powerlessness is heard and integrated into their psychiatric or mental health care plans. Denying trauma as an important factor in one's mental health severely impairs not only the quality, but also the modalities of care offered. Invasive treatments, such as ECT, can be seen as intrinsically re-traumatizing and triggering for women who have suffered abuse, victimization and violence. As such, best practices for trauma-informed work consider how many common procedures (such as intake and discharge from hospitals) within service settings can be retriggering. Procedures must be growth-promoting, safe and relevant to the client's needs. Most importantly, practitioners must assume that all clients they encounter have suffered from trauma at some point in their lives (Eliot 463).

Psychiatrist and ECT-enthusiast Dr. Max Fink emphasizes in his book *Electroshock: Restoring the Mind*, patient stories of "memory erasure" are read as grossly exaggerated and "groundless" (Fink 17). When he says people's fear of losing memory as a result of ECT is a "groundless" statement, he devalues decades of first-person testimonies that describe the trauma and experience of "memory erasure." Fink's argument stands because "memory" is a "slippery phenomenon" that is difficult to objectively measure. What *can* be objectively measured, however, are the physiological and neurological effects of ECT. The procedure is clinically documented as causing brain trauma, internal hemorrhaging, cell damage, and other serious physical impairments (Breggin, *Toxic Psychiatry* 8, Burstow, *Psychiatry and the Business of Madness* 16). These precarious side-effects occur in addition to memory problems. He claims the anesthetics and/or the "mental illness" themselves are to blame for memory loss and disorientation, not ECT. He writes, "Sometimes, a patient fears that electroshock will impair the skills that are the basis of their livelihood. That fear is groundless. It

was the mental illness, not the treatment, that may have impaired their knowledge. The student who regains her normal mental state through treatment can return to her studies with the same skills she had earlier” (17). Fink goes on to say how depressive patients do not have “good” memories to begin with and “register the events of their lives poorly” (17). Fink’s statement silences, trivializes, and invalidates the very possibility of speaking about “memory erasure.” If patients’ voices are “groundless,” then psychiatric authority is reinforced as the only voice worth listening to within the ECT debate. A simple internet search regarding the history of electroconvulsive therapy reveals a plethora of revival articles announcing 80 years of success and very little attention to the voices of dissent or critique. As one medical historian puts it in the *Psychiatric Times*, ECT “is an important treatment suddenly disappearing for cultural reasons” (Shorter 3). This statement ultimately obscures the thesis of my dissertation. We need to listen to psychiatric survivors who have been speaking out for generations about their experiences with non-consensual or coercive ECT and its impact on their memory and cognition. Their reasons for being dissatisfied are lived and experienced in their everyday material reality, not in some abstract statistical frame.

What is Electroconvulsive Therapy?

Before delving into the history of ECT, I first want to explain how it is currently defined and understood within medical practice. Electroshock therapy, also known as Electroconvulsive Therapy or ECT, is a psychiatric procedure that involves passing 100 to 190 volts of electricity through the patient’s head in order to cause a convulsion or grand mal seizure (Breggin). The American Psychiatric Association (APA) wrote an official statement for Electroconvulsive therapy (ECT) that says it “is a safe and effective evidence-based medical treatment. ECT is

endorsed by the APA when administered by properly qualified psychiatrists for appropriately selected patients” (APA Board of Trustees 2015).

Categorized by the Diagnostic Statistical Manual (DSM) as an invasive treatment, at its most basic definition, electroconvulsive therapy is the clinical event of an electric current passed briefly through the brain, via electrodes applied to the scalp. The amount of current to induce a seizure (the seizure threshold) varies from anywhere between 0.75-0.9 amps and 70-450 volts. The voltage is adjusted for every individual who receives ECT, and most psychiatrists follow a risk/benefit analysis where they assess the patient’s diagnosis, symptoms, treatment history, medical risks, and anticipated speed of action/efficacy (Kaplan and Sadock 564). However, the most common voltage is 100-190. The patients’ answers determine the placement of the electrodes (unilaterally or bilaterally), as well as the amount of treatments they will receive. At the start of a treatment plan, psychiatrists usually recommend six to twelve sessions (Kaplan and Sadock 564) three times per week, which is then reduced to once a week. The total procedure takes anywhere between 30 minutes to an hour (oxygenation, anesthetics, convulsion, and recovery). Electrodes are placed either unilaterally or bilaterally on the patient’s scalp, and “the most common approach is to initiate treatment with unilateral ECT because of its more favourable adverse effect profile” (Kaplan and Sadock 564).

Although ECT procedures are not formally standardized globally, in North America, patients are almost always put to sleep with anesthetics and given muscle relaxants to prevent injuries from convulsions. Informed-consent is now obligatory before a psychiatrist can administer ECT—however, there remains some controversy over what counts as informed-consent when dealing with patients who are severely incapacitated due to mental suffering. Quite simply, informed-consent means that the patient is given sufficient education materials to

warrant an “informed” decision. Generally, psychiatrists provide information sheets with a description of the procedure, potential risks/benefits, option to refuse treatment, immediate side-effects, long-term side-effects, and actions to take in case of an emergency (i.e. to call a physician immediately if they suffer a spontaneous seizure of any kind). Some psychiatrists will have patients view a short procedural film to demonstrate, visually, what to expect, and assuage fears.

Despite renewed and rigorous informed-consent procedures, under the current Mental Health Act in Ontario (and in most of North America), a patient can receive court-ordered treatment (forced-treatment) regardless of whether they consent or not. “Forced-restraints” or “forced-treatments” are guided by policies meant as a “last resort to prevent self-harm or to others”. Under the “medical model” of psychiatric care, expert-knowledge (doctor, psychiatrist, nurse) dominates interpretation of “last-resort” and “harm” when weighing the pros/cons of forced treatment. A recent clinical audit in the UK demonstrates that most recipients are still women (66%) and over 60 (56%). More than a third (39%) is given without consent, with 30% of Trusts not adhering to mental health legislation concerning second opinions. At least 44% were not using validated measures of efficacy, and at least 33% failed to do so for adverse effects (Read et al. 263). Only four provided any actual data for positive outcomes or adverse effects. None provided any data on efficacy beyond the end of treatment. Thus, even attempting to define ECT objectively, as a clinical event, cannot escape the political economy in which it is administered. Many theories about “how” ECT works have been proposed, but none have been proven to date (Challiner and Griffiths, Breggin, Bustow, Weitz). The gender and age bias with ECT treatment is one that continues today and one that Janet Frame highlights in her account *Faces in the Water*.

Later in this chapter, I explore the historical underpinnings and feminist critical analysis of the gendered dynamic of psychiatric invasive treatments like ECT.

Despite clinical efforts to ethically inform patients about ECT and its potential risks, several scientific studies on patient perceptions and experience of ECT discuss how “perceived coercion” and “fear” remain quite high (Chakrabarti et al. 529). Perceived coercion, which is predominantly what Janet Frame experienced as recounted in her book *Faces in the Water*, occurs when a patient believes that they have no choice but to accept the treatment as presented to them, even if they have not been ordered by law to do so. The problem lies in the fundamental power imbalance between patients and psychiatrists, most evidently when the latter refuses to take the former’s accounts of distress seriously. In a medical paradigm, patients are not considered the experts of their own care, despite the emancipatory language embedded in psychiatric care plans and “patient engagement” initiatives, which I discuss in further depth in my conclusion. Perceived coercion is coercion. Calling it “perceived” delegitimizes accounts of feeling pressured into saying “yes” to a treatment that might cause harm, whether it was intended or not.

Systematic reviews by service-user researchers (Rose et al.) on coercion, estimate that one-third of patients consent to ECT under pressure. A study to determine why patients consent if coerced suggests that they trust their doctors partially because they are in a state of “desperation” and have no other option at their disposal (Johnstone, Froede and Baldwin; Koopwitz et al; Philpot et al; Rajkumar et al.). One of the most alarming findings described by researchers is that patients make these decisions based on “mistaken beliefs...that ECT would erase all of their unhappy memories” (Tang et al.; Rajagopal; Malekeian et al.), which again discredits actual cases of psychiatric survivor testimony about the adverse side effects of ECT

and memory loss. These testimonies are not “mistaken beliefs” or “perceived coercion”; they are testimonial evidence of impact and should not be used to minimize the validity of a patient’s voice, nor to impede the need for a second opinion. Nancy Fraser’s concept of “misrecognition” (108) is useful in this instance. According to misrecognition theory, patients will not be treated as equals if they display any negative emotion or critique; they will only be further pathologized. Fraser reframes identity politics through the concept of recognition and renders it more complex by bringing this into relation with economic and political distribution. Thereby she avoids a reductive and essentialist account with testimonial or how experiential knowledge often is accused of reproducing. I understand that it might seem contradictory to want to listen to someone’s testimony as truth while deconstructing truth as a socially and politically constructed discourse, but I think in this moment it is important to remember that what counts as knowledge is never neutral, even when it comes from the disenfranchised or from the ground up. Knowledge must always be historicized and put into context, or it risks reproducing the same power dynamics that hold its subversive potential hostage. My question throughout this dissertation is more about how we can honour the voices that counter the smooth “recovery narrative” (Woods, Hart and Spandler) of ECT by listening otherwise.

Birth of Clinical Electroshock in Psychiatry: A History of Erasure

Electric eels, Leyden jars, and shock machines: the potential of electricity’s curative powers has mesmerized natural philosophers, scientists, and physicians for centuries. In response, new technologies were developed for channeling electric currents to intervene in unsolvable health problems, namely disturbances of the mind (Bertucci, Kneeland). Ancient medical authorities, such as Galen, used the shock of electric fish for treating a number of ailments such as epilepsy,

melancholia, and depression (Kneeland xxiv). Centuries later, in 1600, William Gilbert in England published *De Magnete*, a treatise on properties of amber and other “electrics” (Kneeland xxiv) that provoked a new field of therapeutics called “medical electricity.”

The historical canon of ECT is as contradictory as the treatment itself; however, the history that one might find in psychiatry textbooks is a linear, cathartic journey with a central hero: Ladislaus von Meduna. When medical students learn about the history of ECT, they are engaging with a refined narrative of forgetting, a coherent story that erodes the rough edges of criticism and discontent. Thus, the dominant biomedical story of ECT, written primarily by male psychiatrists: namely Mowbray (1959), Sandford (1966), Fink (1979-1984), Brandon (1981), Persad (1988), Endler (1988), Abrams (1988) and Shorter (2001)—praises Meduna as the sole creator and excludes voices of (primarily women) patients or ECT survivors. This history also discounts the long tradition of electrical experimentation on non-consenting women patients within psychiatry as well as natural philosophy, known as medical electricity, which predates modern-ECT by several centuries. Adjacently, the biomedical historicization of ECT performs the memory erasure it is accused of causing to former-patients. Therefore, applying a discursive analysis to the “great continuities of thought” (Foucault, *Archeology of Knowledge* 4) behind the representation of ECT will reveal more than its “origins”—but a history of ideas surrounding madness/sanity that interact with the concept of ECT as treatment. Although the biomedical community might want to name ECT’s singular origin as the brain-child of Ladislav Meduna, such an utterance erases the complexity and genealogy of the idea that electricity could cure madness.

Diminished as being “besides the point” (Abrams 45), medical electricity has little (if any) valued mention within the ECT historical repertoire. According to historians such as

Richard Abrams, medical electricity should not even appear in the same chapter as ECT because it corrupts and confuses the story: “ (...) medical electricity has nothing to do with ECT, and is besides the point. ECT evolved *solely* as a result of Ladislaus von Meduna’s *original* investigations on the effects of camphor-induced convulsions in schizophrenic patients” (Abrams 5). Words like “original” and “solely” are used by Abrams to suggest the deep ideological divide between the arts and sciences, ECT was the work of pure, scientific experimentation by a genius “original” thinker. Medical electricity, seen as a primordial, un-scientific entertainment unrelated to early bio-psychiatry, such as camphor and insulin shocks, is believed to have “nothing to do with ECT” (Abrams 5). Such admission would diminish ECT’s revival campaign funded by the American Psychological Association (APA) that markets it as “safe and effective” (Abrams 5). Thus, ECT is strategically disassociated from medical electricity, and even shock therapy, because such allegiance would damage the public attitude. As Norman Endler, psychologist and ECT-user, states “just because ECT has been misused or used carelessly and sometimes indiscriminately does not mean that it lacks a proper place in the treatment of affective disorders” (62). However, to exclude the critique made by psychiatric survivor micro- histories to the master narrative of ECT as an objective and scientific treatment suggests a deeper struggle for knowledge-power by the biomedical community. Abrams’ search for scientific origins and praise for “original” thinking assumes that ideas are born out of a singularity instead of from collective interacting singularities. The scientific paradigm suggests that somehow scientists are not situated within communities who share traditions and methods, and who relate to wider systems of knowledge production within the public sphere. As Foucault reminds us in *The Archeology of Knowledge*, the problem with historical representation and analysis is:

not how continuities are established, but how a single pattern is formed and preserved, how for so many different, successive minds there is a single horizon, what mode of action and what superstructure is implied by the interplay of transmissions, resumptions, disappearances and repetitions, how the origin may extend its sway well beyond itself to that conclusion that is never given—the problem is no longer one of tradition, of tracing a line, but one of division, of limits (...) History is the work expended on a document—it is not memory—it is one way in which a society recognizes and develops a mass of documentation with which it is inextricably linked. (4)

Foucault theorizes away from a stable secure notion of historical *origin* that sets up artificial, narrative boundaries between the migratory circulations of ideas that transcend time/space. What Abrams is not transparent about is his biomedical investment at the expense of a broader humanistic perspective of ECT's history. His angle is divisive, necessarily limited because it aims to conquer the ECT knowledge-economy.

My research has shown that electricity and *shock* have a long history within biopsychiatry's aim of curing the mind, while covertly pathologizing social inequities. As stated in *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences and Clinical Psychiatry*, early forms of shock treatments were performed by Paracelsus, a Swiss physician, in the 1500s. Paracelsus conducted experiments of inducing seizures by administering camphor to treat "insanity" or "lunacy" (unsoundness of mind influenced by the moon), which would be labelled as "psychiatric illness" by today's medical system. He published his findings in *Diseases Which Lead of a Loss of Reason* (1520), revolutionizing perceptions of mental health issues by proving they were not caused by demonic possession, but rather from natural causes that could be cured

using alchemy or other physiological interventions (such as bleeding-out, hypothermic shocks using ice water, camphor-induced seizures). Although electrical interventions were used prior to Paracelsus' experiments, his work legitimized them as "scientific" measures, meaning they adhered to reason and followed a deductible, observable method. *Pushbutton Psychiatry: A Cultural History of Electroshock in America*, traces ECT's conceptual origins, the idea of passing an electric current through the body, to Ancient Rome, where electric eels were used to treat melancholia (Kneeland and Warren, 25). However, it was not until 1785, during the height of the Enlightenment (and what Foucault would call the categorical "ordering" of knowledge) (Foucault, 18), that the first medical report on the uses of camphor-induced seizures appeared in the *London Medical Journal* (Henry and Sackheim).

Contrary to Abrams, I see a direct correlation between medical electricity and modern ECT, part of which is the common use of electricity/shock on the body in an attempt to "cure" illness, but most importantly, it resounds with ethical issues surrounding how recovery is framed within bio-psychiatry. Binaries such as health/illness, mad/sane, good/evil, objective/subjective all interconnect within this story of ECT. Thus, the healing "power" of electricity to restore the body's equilibrium is not a new metaphor—it is just one that we have forgotten.

From Frankenstein to Benjamin Franklin, the fantasy of restoring life via electricity is a cultural specter that still circulates and shapes how we understand the power of biomedicine today. Transcranial brain stimulation, a less invasive version of ECT, is a new science that builds upon old concepts of electrical miracles. Furthermore, early Victorian electrotherapeutic developments, such as medical electricity were anchors of psychiatric "professionalization" (Kadosh 29) and the impetus for a rise in bio-psychiatric knowledge-power (Foucault). As Kadosh explains: "doctors and psychiatrists who promoted it (electrotherapy) strove to

differentiate themselves from the numerous quacks, healers, and instrument makers active in the medical marketplace by various means, including claiming superior knowledge, education, and expertise” (Kadosh, 29). Thus, the dominant “story” that explains how ECT came to be, is one mainly written and legitimized by psychiatrists who endorse the treatment.

The historicization of ECT as a once dangerous and experimental practice now modernized into a “safe and effective” treatment serves to dispel its negative reputation within popular consciousness, and to legitimize its current use. As Chakrabarti et al. state: “Primitive practices of the past, negative media representations, irrational fears of electricity, all contribute to this public disapproval” (525). The progressive narrative arc within this history, whereby ECT evolves from “bad” to “good,” reads almost as a bildungsroman, a coming-of-age story with a cathartic ending. ECT is “now” safe and effective, a “cure” for untreatable depression, and biopsychiatrists are desperately trying to make the shameful traumatic events of its past usage disappear (Endler 6). This view of ECT’s history forgets major events, survivor testimony, and narrative accounts that contradict its smooth, seemingly “objective” progress as a treatment.

Conversely, within popular consciousness, ECT is thought to be an archaic psychiatric practice that is no longer in use. As Shorter recounts: “ECT had changed from being a first-line treatment for depression in the 1940s and 1950s to merely an approach to treatment-resistant depression in the 1990s” (3). Most people, when I tell them I am writing about ECT, exclaim: “They still do *that*?” Their shock reflects a cultural amnesia surrounding the treatment, which fuels the medical marketing campaign to salvage ECT’s therapeutic image. Many people, when I tell them about my project, have also volunteered stories of lived-experience that usually begin with “my mother had ECT...or my aunt...or my grandmother,” all in-line with the gender-based statistics that render ECT the primary treatment for women who suffer from depression.

Therefore, to work-through these knots, I engage with a counter-history written mostly by self-identified women psychiatric survivors, critical psychiatrists, and allies who interrupt the narrative linearity of ECT's "progress" or evolution into a "safe and effective" treatment. These testimonies also remind us that ECT never left the psychiatric tool-kit, but merely left the public eye, and continues to be administered behind institutional walls. To elucidate the complexities of ECT's genealogy, I examine promotional materials from the 1930s to today: how have bio-psychiatrists sold ECT to the public, gathered informed-consent, and how they assuage fears using popular forms of communication (journalism, drama, brochures, videos). I work with ECT memoirs written by bio-psychiatrists who underwent the treatment, as well as patients who are pro-ECT, and psychiatric survivors who describe it as a form of "memory erasure" or punishment. These autobiographical narratives either assert or interrupt dominant ECT history. I work with major counter-cultural and political histories of ECT such as *Pushbutton Psychiatry: The Cultural History of Electric Shock Therapy in America*, *Shrink Wrap*, *Doctors of Deception*, amongst others. These texts counter the seeming naturalness of ECT history as a linear scientific account of "progress" and highlight the construction of madness as a socio-political device to control deviant bodies and yield significant psych-industry profits.

The medical autobiography or "recovery narrative" (Woods, Hart and Spandler) is always a story conditioned by the clinical, and it is a version of selfhood framed by the doctor's gaze (and more often than not, articulated with the doctor's language). Namely, as Leigh Gilmore asserts, there is always already the struggle of how to represent oneself within ambits of power that govern, discipline and code the "self". Strict and deterministic identity categories such as gender, race, class, ability, sanity etc. are produced and reproduced by national ideologies, social constructs, governmentality (Foucault) and subjective performativity (Butler). Although

performativity (the art of playing with one's codified identity, of subverting scripts and interrupting dominant representations) troubles the facile, easy-to-read assumptions we attach to bodies and how they identify. However, Gilmore is referencing something a bit less forgiving and hopeful. She uses Foucault's notion of "technologies of self" produced by power-knowledge and applies it to the inquiry of autobiography as a genre that either reflects or interrupts dominant narratives of "what a person is" (Gilmore, *Autobiographics* 17). She writes, "In autobiography, identification entails reproducing the complex ideology of 'identity,' variously inflected in the categories of 'personhood,' 'citizenship,' 'women,' and so on" (Gilmore, *Autobiographics* 23). For instance, in a medical setting, the patient rarely authors their story of subjective illness; it is the doctor who frames what is *said* and translates it into a universal medical language for interpreting the symptoms and drafting a treatment plan. The person, as a complex ecosystem of perception, memory, and subjectivity, is eclipsed by the term "patient". Thus, nuanced and ambivalent aspects of selfhood are given up immediately. As Foucault reminds us, "a self cannot reform the power-knowledge relationships we find ourselves in" (45). As soon as someone admits to being "ill" and relays their story of distress to a doctor, they give up sole authorship and enter a dialogical form of writing "I". Case studies, as a medical genre, frame and construct "the patient" as a character in a story of illness, thus it becomes challenging for the person beneath the patient to speak. The illness and the person become intrinsic to one another; they co-exist. Selfhood, just like identity, is not static or stable, it shifts and twists as our bodies move through time/space.

At the root of Michel Foucault's genealogical project on madness, and his ethical critique of psychiatric methods, is a desire to tear down the socio-historic walls built between the mad/sane. His goal is to question commonly held assumptions regarding "madness" as an

organic process with a definite, locatable, biological origin. Instead, he wants us to see madness as a socially-constructed, historically incurable *idea* that can imprison, restrain, and limit one's subjectivity. Thus madness, according to Foucault, becomes a limit-case. Although psychiatric authorities throughout history would argue that all interventions, no matter how risky, were done to help people overcome hopeless suffering, Foucault exposes the power dynamics of such treatments, which in some cases impeded patients' subjectivity and agency (i.e. lobotomy, ECT). His genealogy proves how the walls that were once the brick and mortar of asylum-era care are now transposed into new techniques of restraint (chemical, somatic) that perpetuate unquestioned faith in the discursive binary between psychological "normality" and "abnormality". In *Madness and Civilization: the Invention of an Idea*, Foucault says:

(...) the more one regards the unity of the human being as a whole, the more the reality of an illness as a specific unity disappears and the more the description of the individual reacting to her situation in a pathological way replaces the analysis of the natural forms of illness. (16)

Denaturalizing madness, taking it out of the medical case study frame, may allow it to speak on its own terms. Madness as communicative limit-case echoes a deeper metaphorical wound: How is the Western psy industrial complex meant to care for the experimental subjectivity of patients if it is based on a biomedical and economic model that emphasizes the "body-as-a-machine" (Loftus 214) wrapped up in ideals about productivity and progress? ECT becomes an attractive solution when the mind is conceptualized as a computer that can be rebooted instead of as phenomenological consciousness that cannot be reduced to an object.

The narrative straitjacket that the psychiatric case study places on the individual relates to how ECT survivor testimony is excluded from dominant medical history, and it ironically

mimics the memory erasure that survivors experience. Jonathan A. Lieberman in *Shrink: The Untold Story of Psychiatry* (2015) writes the history of psychiatry from a psychiatrist's perspective—as if it were a subversive feat. His claim that this expert perspective is marginalized and “untold” serves to distract from his position of power and investment in purely biomedical understandings of mental health. In the chapter on ECT, entitled “Electrified Brains” he writes, “For the first time in its long and notorious history, psychiatry can offer scientific, humane, and effective treatments to those suffering from mental illness” (10). He also credits L. Meduna as the “sole” creator of ECT saying that “Amazingly, Meduna discovered that psychotic symptoms really diminish after a metrazol seizure” (166). He later says that ECT might sound absurd to lay persons, but that at that time (1934) “there was still no effective treatment for severe mental illness beside insulin coma (...) 100 volts of electricity through a person's skull was worth the risk (...) it was truly a miracle treatment” (167).

Lieberman ends the chapter with a case study from his own clinical practice. He tells the story of Genevieve, the wife of a famous restaurateur in New York City. He begins by describing her physical appearance, using qualifying adjectives that conform with normative ideals of femininity: “She was a beautiful middle-aged woman” (170). Although her beauty has nothing to do with her mental health, his mention of it suggests inherent sexism regarding the ways a woman's body *should* age—and how it somehow mirrors her internal, mental “symmetry”. If she were unattractive, would that somehow aggravate her mental suffering or his judgement of her body? The onset of her mental breakdown is described as: “her usually impeccably mannered and charming demeanor would devolve into moaning and rocking (...) Genevieve would break into loud baleful songs in her native French, sounding like a wounded Edith Piaf” (170). Demonizing her voice, her use of a language that she identifies with from childhood symbolizes

his disdain of her emotional world—her nostalgia and pain. We never hear from Genevieve; her “madness” (and surely her anger) is contained within Dr. Lieberman’s frame. She is no longer “impeccable” and “well-mannered” but a raging “monster” (170). After ECT, Lieberman describes Genevieve as “calmer”, returning to her “usual courteous self” and he notes how her husband “could not thank me enough” (171).

Regimes of gendered embodiment and codes of sanism are woven within Lieberman’s case study, even though his book seeks to dispel personal bias from the field of psychiatry—his case study reflects his personal judgements and opinions about the ways in which Genevieve should act as a woman. There is nothing “objective” about it. His case study is narrative construction, where he reads the patient and interprets her behaviour through a lens of commonly held assumptions and judgements about “normalcy” and “sanity” that are highly fashioned within a “heteronormative matrix” (Butler, *Gender Trouble* 206). Butler challenges gender identity as a static category because our experiences of gender cannot be captured by the boundaries of identity. Gender is a fluid concept that is not necessarily coherent or aligned with sex—thus our gender subjectivity is a floating signifier with various meanings injected into it—there is no essence. The “heterosexual matrix” is a discursive system where one’s subject position is rendered coherent if it consists of a “stable expressed through a stable gender...that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality” (Butler, *Gender Trouble*, 206). Even though Lieberman may appear to root his argument in biological symptoms with medical language such as “recurrent episodes of psychotic depression that manifests with depressed mood, extreme agitation, and delusion-driven behaviour” (170), his statements operate within “the heterosexual matrix” where deviations from heteronormativity, which encompasses not only heterosexuality but normative gender

performances and a normative sex, are cause for consternation, discipline and Othering. The case study operates within a socio-political ambit of mental health, and in Lieberman's case, it can highlight mythologized ideals of gender embodiment. Without Genevieve's story, no one can know for sure what led to her emotional outbreak, to her anger that was diagnosed as "psychotic depression" and demonized for her "loud baleful songs" (171). Female-subjects (interpellated, socialized, self-identified, and embodied as women) are told that their anger is unhealthy (Butler, *Gender Trouble* 206), leading to its medicalization or suppression instead of its meaningful integration. Rarely are representations of female madness understood as silenced or diverted anger, partly because women rarely get to speak about their anger without it being pathologized by experts. As Leigh Gilmore reminds us: "One must follow a route of estrangement from dominant codes of meaning and look again at the microhistory of cultural production" (*Autobiographics* 2). Historically women psychiatric patients were not encouraged to express their anger in healthy or creative ways; instead, they are introduced to ways to suppress and "quiet" their anger as we see in Janet Frame's novel. This is also reflected in contemporary statistics on ECT and coercion: three times more women than men are electroshocked, and elderly women are at greater risk of being given shock without any prior treatments suggestions.⁷

² Read, John, Christopher Harrop, Jim Geekie and Julia Renton. "An Audit of ECT in England 2011–2015: Usage, demographics, and Adherence to Guidelines and Legislation." *Psychology and Psychotherapy: Theory, Research and Practice*, vol. 91, no.3, 2018, pp. 263-277. <https://onlinelibrary.wiley.com/doi/full/10.1111/papt.12160>.

Here's an excerpt from the Introduction: "ECT remains one of the most controversial of psychiatric treatments. Several meta-analyses conclude it is an effective treatment for depression (Gabor and Lazlo, 2005; Greenhalgh, Knight, Hind, Beverley, & Walters, 2005; Kho, van Vreewijk, Simpson, & Zwinderman, 2003; Pagnin, de Queiroz, Pini, and Cassano, 2004; UK ECT Review Group, 2003; Van der Wurff, Stek, Hoogendijk, and Beekman, 2003). A 2010 review, however, noted that none of these meta-analyses identified any evidence that ECT had any benefit, compared to placebo, beyond the end of treatment and that there is **no evidence that ECT prevents suicide** (Read and Bentall, 2010). The most recent review also failed to find a single study showing that ECT is superior to placebo beyond the end of treatment (Read and Arnold, 2017). The National Institute of Care and Excellence (N.I.C.E., 2009) has stated that 'Further research is urgently required to examine the long-term efficacy and safety of ECT'. Other reviews (Rasmussen, 2009; Ross, 2006) had reached similar conclusions to the 2010 review, such as 'Rigorously defined endogenously depressed patients did exceptionally well with sham ECT'

Thinking through themes of anger suppression and coercive medicalization and treatment, I often think of Audre Lorde's 1981 essay entitled "The Uses of Anger" that centers anger as a productive and powerful emotion to fuel social change in context of anti-Black racism response and white fragility. Lorde explains how her anger is not heard by a white woman who is listening to her speak at an academic conference. She highlights how her experience as a Black woman is erased by having to attend to the feelings of a white colonial audience who cannot hear her anger because they cannot accept accountability and complicity in sustaining the root cause. As Lorde says:

I speak out of direct and particular anger at an academic conference, and a white woman says, "Tell me how you feel but don't say it too harshly or I cannot hear you." But is it my manner that keeps her from hearing, or the threat of a message that her life may change? (7)

I can hear a parallel in Lorde's statement and in the women ECT survivors' life writing I encountered during my research. Receiving their anger as a legitimate critique of systems of oppression (white supremacy, colonialism, patriarchy) would mean that psychiatry could no longer pathologize their experience as illness without attending to their complicity in upholding systemic violence. The harshness of Lorde's critique is nothing compared to the harshness of

(Rasmussen, p. 59). The controversy also focuses on the extent to which ECT causes long-lasting memory dysfunction and increases mortality (Breggin, 2008; Fosse and Read, 2013; Read et al., 2013; Rose, Fleischmann, Wykes, Leese, and Bindman, 2003; Rose, Fleischman, and Wykes, 2004; Sackeim et al., 2007). The controversy includes the issues of when ECT should be used, and on whom. Some consider it the treatment of choice for several disorders. Others argue it should never be used. A common position is that it should be used only as a last resort, and only when other treatments have failed." (Read et al. 263).

Another excerpt: "**Most recipients are still women (66%) and over 60 (56%).** More than a third (39%) is given without consent, with 30% of Trusts not adhering to mental health legislation concerning second opinions. At least 44% were not using validated measures of efficacy, and at least 33% failed to do so for adverse effects." (Read et al. 263).

living in a racist, sexist, homophobic, ableist, sanist, anthropocentric society. Listening otherwise (Levinas, Lispari, Voegelin, Todd) to harsh critique creates space for self-reflexive dialogic responses and accountability (as Lispari calls *response-ability*) that can subvert violent paradigms. In the postscript of this dissertation, I reflect on the link between anger, critique and the silencing form of “patient engagement” (Johannesen) that currently functions as a form of “ethical domination” to uphold the psychiatric status quo over knowledge-production. The moral capital of psychiatry remains entrenched in the neutral and nice “engagement turn” that sells stories of patient recovery that align with medical outcomes, not social justice (Costa et al. “Recovering Our Stories” 86).

The gendered dynamics at play within how women testimonies, intersectional identities and accounts of distress are attended to within psychiatry seem to lack any critical theory or feminist analysis. One activist that harnessed her anger was Wendy Funk, who before publishing her memoir *What Difference Does it Make* (which I cite later in this chapter) wrote extensive letters to the media, press, and networks discussing how medically biased representations of ECT were spreading misinformation, belittling survivor testimony and distorting the potential harm regarding “memory erasure”.

Her anger was diplomatically mobilized, yet still, it remained unheard by decision-makers or media executives. In a letter to “Good Morning America” dated May 23rd, 1996 she states in response to an interview with Dr. Tim Johnson about how ECT has been modernized and is harmless:

He stated that the memory loss resulting from this treatment is temporary and that there is no evidence that it causes structural brain damage. There are thousands of people who have had much more than temporary memory loss with modern and

new machines. Some survivors of this treatment have lost several weeks, some have lost several years, and I myself have lost an entire lifetime of over 30 years. It was simply erased by this ‘safe, effective treatment’. (Wendy Funk, letter to Jeanne D’Agostina, May 23rd, 1996: Psychiatric Survivors Archives of Toronto, Don Weitz Fond)

Funk did not receive a response to her complaint to “Good Morning America”, which while not surprising, shows how survivors’ lived experience is not invited into public discourse or debate with the same enthusiasm or respect, and how their claims are completely disregarded by the medical community. In a complaint to CTV about a 1996 television movie called *All She Ever Wanted* and its sensational depiction and misrepresentation of ECT, the Vice President of the network wrote back to Funk saying “we do not want to get into a debate about the status of psychiatric treatment” (Letter to CTV April 30th, 1996, Psychiatric Survivor Archives of Toronto, Don Weitz Fond). This response invalidates Funk’s complaints and ignores how the movie’s representations of a woman struggling with bipolar disorder and receiving ECT was “degrading, insulting and violated her dignity” as a survivor. Funk lost 30 years of her life to ECT (Letter to CTV, April 30th, 1996, Psychiatric Archives of Toronto, Don Weitz) which she elaborates in her 1999 memoir *What Difference Does it Make*.

Her anger was heard by fellow survivors and activists, like Don Weitz, the Toronto editor and publisher of *Phoenix Rising* (see chapter 2), the first publication solely run and dedicated to psy survivor activism and analysis. Their correspondences demonstrate the power of community organizing to hold space, validate and listen to survivors testimony. Weitz encouraged Funk to write her memoir (based on journals she kept in the ward) and to continue raising public consciousness about her experience of “memory erasure” after receiving ECT that altered her life

forever (Funk 2). In a November 11th, 1996 letter to Funk, Weitz writes “we each have our own memories of survival, struggle, support, love...” He then shares testimony from a scientist and academic who is campaigning against ECT named Peter Sterling, in hopes of building her case against the doctors who gave her ECT without ethical consent and which led to her ongoing memory problems (Letter to Wendy Funk, November 11th, 1996, PSAT Don Weitz Fond).

Mainstream discourse supports an “evidence-based” perspective that only counts one kind of evidence. As Funk names, thousands of survivor testimony is completely ignored, silenced, and rendered invalid. Not believing survivors of injustice or violence at the hands of public institutions or people in positions of power is not new; most marginalized groups face such invalidation and gaslighting on a daily basis. The point is to keep speaking despite not being heard, as seen in Don Weitz’ support of survivors like Wendy Funk. She refused to be silenced, she wrote hundreds of letters in response to representations of ECT in popular media, from movies to talk shows, and demanded for survivor voices to be equitably represented and brought into the public sphere for a more well-rounded debate, one that respects the accounts of “memory erasure” that were being systematically erased from history and from society’s collective consciousness. Even if she might not have succeeded in changing the tone of media representations of ECT, given the current trends we see in popular journalism today, her work did lead to an epistemological questioning of what counts as evidence and bias in psychiatric and pharmaceutical research (Burstow, Breggin, Weitz).

The ECT controversy is deeper than its negative representation in Hollywood films or history books. The lack of faith in psychiatric survivor testimony, the dismissal of their voice and accounts of trauma, begs the question: what happens to conceptions of recovery as a continual, individualized process when it aims for a universal, fast-acting, hyperbolic “cure”? Is recovery

even possible when it is described and understood within a dichotomy of miracle/erasure? Who can speak about recovery? Whose voice matters most when it comes to legitimizing and describing what counts as *effective and safe* treatments? Although narrative has long been recognized as a “key technology of recovery,” (Woods, Hart and Spandler) there has been little critical investigation into how recovery narratives are constituted and mobilized and with what consequences. Recovery has been co-opted by psy institutions, stolen from the psychiatric survivor discourse and praxis. Recovery was once a movement of liberation from the epistemic shackles of the medical model; now it functions within the machine of psychiatric knowledge-production and power. Bonnie Burstow, in *Psychiatry and the Business of Madness*, uncovers Dr. Max Fink’s current monopoly over electroshock research, public relations, and education. Beyond Fink, she illustrates the systemic functioning of the shock industry, the official and hidden structure of its discursive techniques. She explains how “memory loss” is not seen as a legitimate concern for banning the use of ECT-machines, because FDA “regulations are not trying to assess whether or not ECT intrinsically harms but whether or not the machines function as they were designed to function” (Burstow, *Psychiatry and the Business of Madness*, 206). Furthermore, she links the ideological stronghold that the pro-ECT “PR machine” has created with profits made by the “electroshock empire” (shock machine companies, major research institutions, publishing industries, educational-promotional video companies, professionals [ex. psychiatrists, anesthesiologists]). The history of electroshock is also authored with the industry’s vested interests in mind. For instance, Shorter and Healey’s book *Shock Therapy* is taken as the definitive “history of shock,” while it does not present survivor testimony of the adverse effects or any clinical research that demonstrates the cognitive and brain damage caused by ECT. Unsurprisingly, Burstow reveals how the book project was funded by Dr. Max Fink, further

demonstrating his dominance over ECT knowledge-production (Burstow, *Psychiatry and the Business of Madness*, 208).

The historicization of ECT is one embedded in tensions between the objective/subjective within science. For instance, Richard Abrams praises Dr. Max Fink's translation of Meduna's autobiography because it tells the "accurate" story of ECT (Abrams 3), one that illuminates its biomedical origins. It is a version of ECT's story where objectivity conquers subjectivity, where psychiatry's major turn towards the brain is depicted as a feat of "intellectual curiosity" over "sentimentality". However, of course, this version of the "objective" story is told from a subjective position. It is Dr. Fink's interpretation of Meduna's Hungarian words—his translation is an intent to showcase ECT as a strictly biomedical procedure far removed from its ancient electrical roots. In the autobiographical translation, Meduna recounts his 1922 medical school interview for psychiatry. After medical school, he had applied for a small research position at the Interacademy Brain Research Institute in Budapest and was interviewed alongside three eager applicants. Meduna describes each of the applicants answers to the question: "Why are you interested in brain research?" (45). Most of the applicants' answers revolved around having deep empathy for people with mental illness, having relatives with schizophrenia and wanting to bring hope to the hopeless. When it came to Meduna's answer, wrought with anger and irritation, he exclaimed: "I am just curious about the structure of the brain and how it works" (45). The next day, he received a letter congratulating him on his acceptance to the research institute. Perplexed, Meduna asked the head scientist why he was chosen over the other applicants and was told: "Doctor, we don't need people in psychiatry who have sympathy for patients or who have humanitarian reasons for becoming psychiatrists. We need people who have intellectual curiosity" (45). Rewarded for his strict biomedical interest, his disdain for the personal, altruistic

side of medicine—Meduna, in this representation, becomes a symbol of cutting-edge research, the promise of scientific intellectual neutrality. His “intellectual curiosity” conquers the “sentimentality” of the other applicants—thereby inferring how intellect cannot be mired with affect, as if the two faculties were absolutely separate and irreconcilable. The divide between the soft/hard sciences is quite evident in his speech. This dichotomy believes hard-sciences are only concerned with the measurable, observable, and concrete, whereas soft-sciences delve into complex phenomena, the intangible, the emotional, and the relational. Hard and soft are antonyms in a semantic power struggle, each under threat by the other. Dividing scientific inquiry along such harsh, competitive lines is dangerous; it means that brain-centric research methods cannot be humanistic or concerned with subjectivity—or that trauma-informed practices, which are deeply subjective, are not clinically evidence-based. Keeping the historical dimensions of Meduna’s speech in mind is important; however, this divide continues in today’s popular consciousness and in clinical ideology. Privileging the biological over the subjective, or as Luce Irigaray says “encoding a world from which subjectivity has been removed and subordinated under the Universal” (33) aligns with ECT as a neutral practice that is meant to reboot a brain as if it were a machine. As Irigaray warns: “the subject has become a machine with no becoming—this is what makes certain discourses successful or unsuccessful, some complicit with general mechanics, but somehow beyond time, without past, present or future” (3). Detaching science from its subject creates a reductionist, disembodied practice that runs the risk of silencing the distress that the patient brings to the clinical encounter. Jeanette Winterson takes up this concept beautifully in her novel *Art & Lies*. One of the three protagonists is a scientist with a taste for the sublime and philosophical—in the opening passages of the novel he contemplates the angle of

his perspective, the ways in which he sees the world informed by science, and the trick of his subjective perception:

My hands shook under the weight of the light. Those heavy yellow squares saturated my palms and spilled down my trouser legs. My clothes were soaked in light. I felt like an apostle. I felt like a saint, not a dirty tired traveler on a dirty tired train. It was a trick, of course, a fluke of the weak sun magnified through the thick glass. And yet my heart leapt. In the moment of the moving pool, my heart leapt. I put my hand on the book, it was warm, it must have lain in the sun. I laughed; a few lines of physics had been turned into a miracle. Or a miracle had been turned into a few lines of physics? I turned to see my own reflection in the black window. No matter how meticulous the scientists he or she cannot be separated from the experiment itself.

(...) The doctor's surgery is full of men and women who do not know why they are unhappy. "Take this," says the doctor, "you'll soon feel better." They do feel better, because little by little, they cease to feel at all. (4-8)

Winterson's depiction of Handel's frustrated quest for certainty and inescapable fear of the inexplicable is coupled with scientific limitations. Science can only answer so much about experience before it must give up and reach for the miraculous or supernatural. Handel's insistence on explaining away the height of his "illuminating" experience on the train, of grounding it in physics, is a form of neutralization and defense against feeling. The "cure" in this passage is the cessation of feeling—which is what Handel is both resisting and embracing. The ambivalence of scientific epistemology suggests the need to forgo certainty by embracing a critical self-reflexive lens, centred on the humanness of the scientist.

Contemporary Engagement with History: The ECT 'Recovery Narrative' and 'Miracle Cure' in Pop Culture

Long after Meduna's autobiography and the conquest of his "intellectual curiosity", the same dichotomous pattern between "objective/subjective" emerges in the contemporary ECT story. In December 2015, *The Atlantic*, published a polemic article entitled: "The Return of Electroshock Therapy: Can Sarah Lisanby help an infamous form of depression treatment shed its brutal reputation?" Beneath the title is a caricature of Sarah Lisanby, a young friendly-looking psychiatrist, in a white lab coat holding an over-sized magnet over an over-sized pink brain. The pink brain sits on an operating table, hooked up to a monitor. There is something silly about the image, yet it emanates a calming sense that somehow scientific progress, and new advances in research, will right the wrongs of ECT's history, separate fact from fiction and align the public with a singular and stable truth. The return of ECT seems hopeful, couched in "evidence-based" language, and Sarah Lisanby does not fit the stereotypical "mad scientist" or "shock doctor" image often associated with ECT. She appears to be a sensible, kind-hearted person who wants to help.

A deeper reading suggests a disembodied, biomedical approach to mental health; a positivist methodology that is brain-centric, objective and entrenched in hegemonic concepts of the Universal (Irigaray 3). Luce Irigaray writes in *To Speak is Never Neutral* how phallogocentric scientific discourse functions within patriarchal systems of language. Scientific modes of reasoning and speaking refuse to acknowledge that their own partiality, their own perspectivity, their own interest in values, implicitly rely upon conceptions of women and femininity to maintain their 'objectivity', 'scientificity', or 'truth,'; that is, their veiled masculinity (Irigaray

5). Irigaray equates the dominant “reductionist” grammar of science to the privileged position of masculine-subjectivity upheld by the grammar of a patriarchal hierarchical world: “the form-giving subject has always been male; they give form to culture and to the history of ideas. Scientific studies prove the sexuality of the cortex, while science maintains that discourse is neuter (...) the female remains within an amorphous maternal matrix, still in the reservoir of meaning, and the madness of discourse” (4). What Irigaray means is that the reign of binarism (male/female, objective/subjective) exhausts any potential for thinking differently about the biomedical and its role in our lives. Ideological understandings of medicine are a set of descriptive, normative beliefs and values that explain and justify how society is organized, and more specifically how health/illness is managed and imagined within the social world. As the image conveys, the brain exists outside of a human body, detached, living as a sovereign entity to be “fixed” in a technical and disembodied way. By this semantic logic, Lisanby is not shocking a person, but rather, she is shocking a brain, placing her electrodes on problematic areas and rebooting them (similar to a computer).

Allusions to the Cartesian mind/body divide are evident in this image, where the brain-centric focus attempts to locate suffering in faulty neurotransmitters instead of in broader environmental, societal and interpersonal relationships. As feminist medical philosophers have demonstrated, the mind/body divide is inherently masculinist (or sexist) as it genders mental rationality as “male,” and the body as irrational and “female” (Irigaray 8). The historic erasure of the feminine in culture is evident in the “deep economy of language” where patriarchal culture has reduced the value of the feminine to “an abstract nonexistent reality” (Irigaray 8). In other words, “language rather than anatomy, now consigns woman to her role as object and Other” (Irigaray 8). Although Lisanby is a powerful woman within psychiatry as the head of the

National Institute of Mental Health, this does not mean she does not adhere to masculinist, paternalistic or gendered ideas of mental health. In a sense, her “minority” position within scientific knowledge-production leverages and distracts from her human, corporeal capital as a white, upper-class, Ivy League-educated psychiatrist. The ambit of power within psychiatry between expert/patient remains the same, where she is “encoding a world from which subjectivity has been removed, and which is subordinated under the cover of the universal, to one single subject” (Irigaray 12). The expedient tokenism displayed in this article, giving the illusion that ECT is not only “safe and effective” but is neutrally and objectively administered outside of a patriarchal medical system, distorts the material-conditions and gendering of invasive mental health treatments within psychiatry.

This is why survivors felt like their complaints against doctors or psychiatrists were never successful or resulted in change in practice, because they were not seen as credible experts, their experience was always pathologized and eclipsed by medical knowledge or expertise. In an April 15th, 1998 letter to Wendy Funk from the College of Physicians and Surgeons (Alberta), the Deputy Registrar discounts her testimony of memory loss by saying its “controversial” and her complaint or anger proves her “emotional illness.” ECT, according to the College of Physicians and Surgeons, saved her life:

Long-term memory loss such as you describe is complex and somewhat controversial, but the general consensus is that the impact of ECT on long-term memory is minimal if there is any at all. Your description included loss of memory for huge blocks of time, a feature not seen with electroconvulsive therapy. In fact, our expert believes it is more likely a feature of your emotional illness than the ECT treatments. He indicated clearly that the equipment used was the state of the art and that the techniques employed were entirely appropriate.

(Wendy Funk- Don Weitz PSAT Fond)

Funk wrote to her activist colleague, Don Weitz, describing how her “consent” was under “coercion and threat of not signing insurance forms unless I followed doctors’ orders or doing a partial lobotomy if I didn’t consent.” She then goes on to talk about how her experience of memory loss is a “fact” and is not controversial. (May 22nd, 1998, Letter to Don Weitz from Wendy Funk in Don Weitz’s PSAT Fond). This exchange is an example of the power of ECT’s history written by and for the psy industry, how it maintains the hierarchy of knowledge and

places survivor testimony at the bottom as mere opinion, or worse, as evidence of their “illness.” Engaging with survivor testimony and history is essential for understanding the complexity of power surrounding evidence and how treatments are framed by the psy industrial complex.

This shiny version of ECT’s history, with Meduna as conquering hero, blinds us to the more nuanced and murky beginnings of electricity in medicine. Electroshock predates psychoanalysis, the discovery of the unconscious, and the idea that trauma could be a persistent, clamouring wound, unseen and unheard by the wounded until they enter a talking-cure or other triggering relations. It also predates pharmaceutical drugs. Early technological interventions, such as ECT, appeared miraculous because, at the time, there were no other treatments to ease distress beyond locking people away in asylums or attics. ECT seemed to bring the most hopeless out of darkness. However, the idea of electricity as having power over existential problems did not start with Meduna, even if he helped legitimize brain-centric methods in psychiatry with the aim of “curing” mental illness through induced-seizures.

Electricity is a definitive modern invention, marking the second industrial revolution known as the “electric age”—it modernized urban life, mechanized labour, and increased the speed of human movement. Electricity stood as a symbol of freedom from drudgery, a symbol of a new way of living. In a sense, electricity was the miracle of early urbanization: it helped enlighten society to new ways of living and working—namely, how to gain mastery over nature. The concept of “miracle” has philosophical and theological roots, and its definition thus varies depending on its context. Generally, a miracle can be understood as transcending the “laws of nature,” an extraordinary occurrence that holds some relevance to the supernatural (Peck 22). Miracle in a medical context suggests overcoming illness or debilitation (even death) in ways

that cannot be explained scientifically or objectively (through laws of nature). It designates overcoming hopeless or “untreatable” physical ailments.

Prior to the official “birth” of ECT, as we know, Victorian electrotherapy was very popular across North America and Europe from 1750 onward—building upon the idea that electrical power could cure what was once believed to be incurable suffering in a flash. Early medical electricity was advocated by a circle of European natural philosophers such as Abbe Nollet (1700-1770), Benjamin Franklin (1706-1790), John Birch (1745-1810), Erasmus Darwin (1731-1802) amongst others (de laPena). Electricity, for a young science, was the most promising branch of experimental philosophy. Mesmerized by the disruptive power of lightning channeled into radical “life-saving” therapies, *Gentleman’s Magazine* in 1745 stated, “natural philosophy can work miracles” (Bertucci 89). During this “age of electricity” (Gilman 340), natural philosophers experimented with electricity seeking a cure for psychological pathologies; perhaps this was because those were the most baffling to treat and understand.

Electrical experimentation helped many understand the psyche in new ways. Historian Borck Cornelius discusses how electricity became defined as an Enlightened Science and the cornerstone of modern medicine: “the blending of psychophysiology and electrical engineering marks the formation of an electric epistemology in scientific as well as public understanding of the psyche” (565). The body was mapped electrically, thus electricity was seen as restorative, a way to recalibrate what had been depleted through the stresses of modern urban life or labour. Prior to this revolutionary technological period, Benjamin Franklin’s famous kite experiment led to a trend in testing electrical remedies for incurable diseases and ailments. Here, electricity was seen as a power greater than other interventions for the most hopeless cases.

The gendered dynamics of early medical electricity are worthy of mention. Many of the metaphors used to describe man's creative urge to interrogate nature with power (de la Pena) align with masculinist hegemony. For instance, Franklin was known for his trials on mute "hysterics"—namely young working-class women who were unable to work due to their "loss of voice" (Franklin 34). This loss of voice, characteristic of hysteria, came with the ancient image of the wandering womb, "a uterus deprived of sexual intercourse and rising in protest into the throat, there to create hysterical symptoms" (ix). Using Leyden Jars and frictional machines that were able to generate sparks on demand, Franklin would treat his patients by shocking various areas of their bodies. In one of his famous case studies, he describes C.B., a young girl with uncontrollable "hysterical seizures" who was given a "globe and bottle" to generate and store electricity so that she could electrify herself at home according to his instructions. The young girl's tongue had been "rolled up" after hearing a violent knocking at the door (Franklin 34) which threw her into a fit of convulsions. Franklin's electric cure helped the girl "calm down" until her speech returned. Electricity was seen as a "powerful" miraculous intervention that even Franklin declared "not to comprehend" (Letters 14). According to *Pushbutton Psychiatry*, there is a long history of shocking women's bodies (Galen's widow treatment and Hippocratic excision of the clitoris) to combat "female hysteria" (Kneeland and Warren 34). The continuities of medical hierarchy and patriarchy resonate throughout the electrical lineage of treating psychological pain—or illnesses.

By the 19th century, a cultural shift occurred in which electricity changed its role from being a power source for experimental science to becoming a medium for curing everyday ailments, such as headaches or fatigue in fast and "miraculous" ways (Kneeland and Warren).

Electricity and the advent of wearable electrical devices to cure illnesses thus helped re-conceptualize the body and its role in the modern project. As Carolyn Thomas de la Pena notes in *The Body Electric: How Strange Machines Built the Modern American*, “Americans gradually moved away from viewing the body as a set entity determined by God and toward viewing it as raw material malleable under man’s direction. The body could be altered by applied energy” (3). Electricity helped re-conceptualize the body. The advent of machines and technologies meant to enhance human performance suggests that electricity carried the body into the modern era, as de la Pena notes: “People saw themselves as part of a modern project, these technologies promised to bring the body along on the road to rapid modernization” (3).

This shift also coincided with the birth of the asylum, an urban peripheral structure of walls and gardens that could reform discipline and separate the mad from the rest of society. This period also intersects with the beginnings of psychoanalysis, where a “talking cure” was developed to interpret an unconscious story beneath the patient’s affect. One of the grandfathers of medical electricity, Alfred Smee, attests to how shock could rebalance the flow of electrical energy in the body. As Kadosh explains, “this was encouraged by an emphasis upon the role of ethereal powers in the natural world and the divine economy, the generally accepted kinship or consonance between electricity and the nervous fluid, and the assumption that all physiological processes within the body were fundamentally electrical in nature” (29). In Britain, “madness” was regarded as a disease of the brain rather than the mind, and therefore it was believed that physical interventions such as electrotherapy or medical electricity would be efficacious. In France, madness was understood as a defect of mind capable of being receptive to psychoanalysis (Kneeland and Warren 14). The electrical “boom” in medicine allowed for “new research regarding the physiological impact of electricity on the head and brain from the middle

of the 19th century helped to encourage applications of electrotherapy and its use as a diagnostic tool” (Kneeland and Warren, 16). Althaus claimed that electrotherapy applied to the spine was able to restore the “power of memory” and “increased disposition for labour” (Kneeland and Warren, 16). Thus, the Victorian era saw the development and use of portable electrical devices, such as the Pulvermacher Chain (see image below), to help stimulate human productivity and cure “nervous maladies”:

Popular machines for transcranial electrical stimulation that dispersed static or frictional, faradic or battery current electricity were available everywhere from London department stores to seaside resorts and used at home. The market for popular electrotherapeutic and transcranial electrical stimulation apparatuses remained strong until 1920. (de la Pena 24)

Electricity was believed to be a powerful force that offered power over life and death, or at least some relief from severe neurosis. As de la Pena notes, “theories of health and rudimentary understandings of energy created an age in which industrial energies seemed capable of curing physical limitations and ill health that plagued Victorian bodies” (3).

The gendering of mental health issues continued into the 19th century; the “madwoman” became a cultural trope, tied to hysteria and the romanticization of female affect. From Ophelia to the “madwoman in the attic”, cultural representations of female madness were often tied to the inability to fit into a gendered-narrative, mythologized and sustained in public discourse⁸. Thus, cultural imagination of mental illness is closely tied to identity-formations that ambivalently undo and reproduce socially-determined “normal” or “healthy” gender embodiments. Typically,

³ Sandra M. Gilbert and Susan Gubar, *The Madwoman in the Attic: The Woman Writer the Nineteenth-Century Literary Imagination*. (New Haven, CT: Yale University Press, 2000).

popular representations of female madness in Western culture invoke notions of social deviance that trouble patriarchal gendered scripts; namely scripts that embellish female docility, romanizations of motherhood and an intrinsic ethic of care. However, during the 19th century, there were no mechanisms for women's voices to be heard legitimately within the public sphere (despite it being the beginning of the early feminist movement with the rise of The Suffragettes), thus mentally ill women were relegated to the sidelines of society, marginalized, locked in cellars and asylums, out of public sight. They were punished for being angry and/or unsettled by their traumatic circumstances (physical violence, sexual assault, etc.). Contemporary feminist literary theorists Gilbert and Gubar praised "the madwoman" as a transgressive and resistive trope against patriarchy—however, during the "age of electricity", female madness was highly fetishized and appropriated by natural philosophers. Exhibitions and public demonstrations of electrical devices were always performed on women's bodies. Rendered into a spectacle for modern audiences, the "madwoman" had become associated with mastery over the body and a sexualized, masculine dominance over nature.

Even though "Medical Electricity" had been in use since the early-modern era, physicians were reluctant to run electricity through the brain because it was a deadly risk. Despite this risk, in 1938, Italian psychiatrists Ugo Cerletti and Bini were the first to attempt electroshock in a clinical setting. Building upon Meduna's clinical notes on camphor-induced seizures in patients with schizophrenia, they ran the first clinical trial of electrically-induced seizures in humans. In the mid-1930s, they experimented on a homeless "cagoods" that wandered around the train stations near the University of Rome. Based on Meduna's research, Cerletti had observed that epileptic patients would become less depressed after having a grand mal seizure, and this prompted his experiments (Burstow, Breggin, Kneeland, Shorter). Electroshock therapy was

popularized during the rise of Nazi Germany's dehumanizing psychiatric experiments on German "mentally ill" individuals. Many of these experiments bordered on torture and were part of a larger eugenics project. As Burstow writes, "the rise of ECT in the 1930s can be attributed to the authoritarian political era in Europe in which 275,000 'inmates' in German psychiatric hospitals were starved, beaten, drugged, and gassed to death" (95). Thus, the birth of electroshock, as we know it, is tied to fascist origins (Burstow) and repressive regimes in which "mentally ill" bodies were dehumanized and seen as contaminants that may pollute the evolutionary genetic future of the human race. Within this framework, mental abnormality went from being understood as a moral defect to a physiological, neurological problem that needed to be either corrected through invasive-intervention, imprisonment, or death (Kaplan).

The first patient to receive ECT, Enrico S., had been labelled schizophrenic and mute. He is often described as the most "hopeless" patient by psychiatric historians and autobiographers, such as Dr. Sherwin Nuland, who recounts in his TED talk on ECT how Enrico was a "lost soul wandering around... hopelessly schizophrenic... defecating on himself, talking nothing that made sense" (TED Talk Nuland). Enrico became the poster-child of the civilizing effects of ECT, as he went from a babbling, defecating "animal" to someone who was humanly self-conscious and socially aware. After several unsuccessful trials of inducing a grand mal seizure using 100 volts, the patient screamed "Attention! Another time is murderous!" (Shorter 41), denoting his awareness, self-preservation, and the dissipation of his catatonic stupor. Cerletti took Enrico's impassioned and assertive statement as proof of the patient's recovery, noting, "the schizophrenic is coming out of epileptic convulsions have a visible sense of calm and repose" (Shorter 43 sic). At the time, no anesthetics were administered and the violent convulsions often

resulted in broken limbs and spines—even death (Breggin, Burstow, Weitz). This bleak image of ECT is what many contemporary psychiatrists are attempting to change.

A promotional film made by Abram Bennett in 1939, entitled *Convulsive Shock Therapy in Affective Psychosis*, describes the treatment as the “most favorable” in treating schizophrenia and depression. The silent film reveals “before” and “after” shots of patients in an American asylum. The film is meant to encourage physicians to try the new treatment on their most hopeless cases. All of the patients are female, and most are elderly. The film opens with a brief history of electroshock therapy, linking it to Meduna’s successful trials and stating its powerful results in terminating severe depressions within a week. Later it showcases women in distress admitted to the asylum. The first woman is sixty-one years old, disheveled, and weeping—because it is a silent film we cannot hear what she is saying and must rely on the film’s subtitles. After electroshock (we do not see what the treatment looks like clinically) the caption below her smiling face reads: “All anxiety disappears, she is euphoric and calm.” (Bennett) Another woman, locked up, is portrayed violently banging on the asylum doors that imprison her—the caption reads “This housewife tried to kill herself, and now she is completely recovered.” We see the woman raising her hands in prayer and the caption narrates: “Things don’t worry me now, I have come back from the dead!” (Bennett). This promotional film aligns with themes of rebirth, miracle, and conquering hopeless suffering. The gendered aspect of the film also echoes how women are predominantly administered ECT—a trend that persists today. Marketing this form of treatment seems to draw upon earlier electrotherapeutic tropes, thus continuing the idea that electricity could cure madness in miraculous ways. The only difference was, at the time of the film’s release in 1939, electricity was clinically approved by psychiatric doctors and medical institutions.

While electrotherapy machines became the objects of medical museums during the late-1970s, electroconvulsive therapy made a “quiet comeback” (Dukakis and Tye 25) in the late-1980s and early-1990s as the treatment of choice for resistant and/or severe depression. The shift has obvious socioeconomic roots in the medical-industrial complex’s paradigm of fast and cost-effective treatments, transforming patient care into a high-turnover assembly line. While strides are being made to include a trauma-informed and culturally-sensitive approach to mental health care, brain-centric ideologies still dominate most psychiatric wards. The global ECT renaissance that started around the late 1980s-early 1990s is a response to the psychiatric survivor movement, patients’ rights groups, mad activists, and other “anti-psychiatry” groups that sought to ban the use of ECT in North America during the 1970s. Leonard Lloyd Frank spearheaded the legal movement against ECT. This counter-history, filled with accounts of trauma, brain damage, and memory erasure, is not seriously addressed by pro-ECT psychiatrists or historians. At the very best, those accounts are regarded as “symptoms” of depression or schizophrenia—or just plain “groundless” statements (Fink). The rhetoric of ECT being “new and improved”, and nothing like the shock treatment of the 1930s-40s, also helps divert attention away from the testimonies that claim it to be traumatic and damaging. As Dr. Burstow writes, “Calling it new and improved serves to create the misimpression that the myriad of voices which rise up against shock are irrelevant for they are complaining about a prior method” (Burstow 95). CBC radio’s *White Coat, Black Art* aired an episode in 2011 entitled “Marketing Medicine” that explored the rhetoric that doctors use to sell controversial or stigmatized treatments, like electroshock. One of the doctors interviewed, head of psychiatry at the University of Ottawa, explained how he combats cultural stigma and gets patients to say “yes” in a hurry through the art of persuasion. “When your brain is out of sync, ECT re-syncs your brain,” he says, to explain

how the treatment works because it is an accessible and comforting statement. Framing ECT as a way to “rebalance” and “re-sync” the brain is a fiction—those metaphors inaccurately depict what happens to the brain after 200 volts of electricity are fired through it, and more importantly, they misrepresent the brain as a simplistic mechanical entity when in fact it is the most complex organ of soft nervous tissues in the body.

Today, ECT takes less than an hour to administer, which is part of its appeal for many who suffer from enduring mental anguish and distress. Its efficiency and promise of “cure” is meant to bring hope to an already overburdened mental health system. In December 2015, the American Psychiatric Association (APA) reported a shortage of mental health beds in hospitals, reflecting the lack of infrastructure and resources allocated to psychological health. In January 2016, the APA tweeted an urgent call to the public to sign a petition in support of deregulating ECT to increase its usage. Due to limited infrastructure, a fast, cost-effective treatment that promises to help the most hopeless cases of depression, especially the suicidal, seems like a viable and welcomed solution for many experts in the field. As a somatic therapy, ECT relies on physiological and brain-centric etiologies, thus moving mental health care away from costly and long-term narrative-based therapies such as psychotherapy and psychoanalysis towards more “efficient” and timely, albeit more invasive, interventions.

Yet, despite the technological progress narrative surrounding ECT, many promoters still rely on the miraculous:

(...) fingers anoint my temples with cool ointment and fasten a plastic crown tightly around my head. Wires connect me to machines that hum and beep, registering the peaks and valleys of my brain and heart. They cover my mouth and nose with plastic and instruct me to breathe. (Manning 9)

Dr. Martha Manning's ritualistic description of her ECT experience in *Undercurrents: A Life Beneath the Surface* (1995) reflects a renewed faith in electrical interventions for serious and debilitating mental distress. She is crowned and anointed, like a high priestess on a transcendental journey, awaiting to be reborn on an operating table. There is a sensuous and spiritual quality to her reflection that echoes Victorian electrical tropes where natural phenomenon, such as lightning, is juxtaposed with ground-breaking technological inventions, such as the light bulb. Awe-inducing scenes of being "struck" with electrical life-force, from Benjamin's Franklin's kite experiment, Mary Shelley's reanimation in *Frankenstein*, or Emily Dickinson's electric lyric: the cultural imagination of electricity has since generated a language of faith in the inexplicable, a conjuring of the supernatural, and suspension of empiricism within medical discourse. Accordingly, Dr. Manning's medical autobiography, like many ECT-supporters, indulges in themes of rebirth and miraculous recovery, which not only counters popular representations of ECT as a barbaric, brain-frying torture machine—it also subverts empirical methodologies as medicine's only means of measurement. This kind of narrative, one that circulates with contradiction and nuance, illuminates the difficulty of reductionist binary-thinking when it comes to the relief of mental distress.

However, I wonder, how will too much reliance on technological invasive-treatments, even if performed in ethical ways, impoverish psychiatry's ability to deliver integrative and holistic treatment plans that take the patients' intersectional context into account (gender, class, race, ability, etc) as well as broader social-determinants of health? More importantly, I worry that the passive nature of invasive treatments like ECT (where patients are not active participants in the treatment process) and its easy framing as a "miracle" (similar to how Prozac was named a miracle drug) creates the illusion that depression can be cured with the flick of a switch (or by

some divine intervention). Such thinking takes power away from patients, from their creative processes of meaning-making and symbolization to cope with existential distress, trauma, and social injustices that haunt our world.

In a similar vein, Julia Kristeva writes, “The speaking being is a believing being” (Kristeva 3). She continues “not something I can prove scientifically that may be calculated (...) but a truth ‘we stumble upon’ to which I cannot adhere, that total fatally subjugates me (...) a truth that keeps me, makes me exist” (Kristeva 3). No treatment method is perfect: Even if it can be helpful to some, recovery is a continuous journey of learning how to survive (Kristeva 3). Taking a passive route and handing over the creative energy necessary for cognitive regeneration solely to experts (or invasive interventions) only delays the recovery process, because it does not teach the patient how to integrate their feelings of suffering and redirect them into positive outcomes (healthy relationships, fulfilling and meaningful career, sustainable nutrition, etc).

Although the metaphor of miracle has theological roots, it has been married to medicine for a long time. Doctors’ ability, and oath, to save life is central to this trope, and the rise of complex mental health issues that threaten not only the quality of social life and wellbeing but also life itself, has propelled research into effective treatments that can transcend limitations and “fix” the brain on a physiological level. These extreme measures, such as ECT or lobotomy, reflect the extreme hopelessness and despair of mental distress.

Broadly, a miraculous event is generally defined as an occurrence that is so utterly extraordinary as to shatter the framework of our understanding of nature. Usually, miracles refer to an act that could not be solely performed by humans. Invasive-technological medical treatments seem to defy the laws of nature: they change biological phenomena in the body and often extend people’s lives by decades. Miracles seem to feign empirical explanation, going

above and beyond what can be measured (yet there is a limit to measurement tools—not all natural phenomena can be measured!). It seems fitting for a treatment like ECT, which does not have a solid explanation of how it “works,” to be enamored with the miraculous.

Dr. Robert E. Peck, who wrote *The Miracle of Shock Treatment* in the 1970s as a response to growing medical and social criticism, explicitly describes the treatment as miraculous, calling it “one of those medical miracles that *Reader’s Digest* likes to write about” (13). Dr. Peck invokes the rhetoric of faith healing to illustrate how overcoming a debilitating illness cannot always be explained scientifically (or through the laws of nature). There is theatre in his statement, the kind of drama that pulls a reader in. There is a certain risk involved, even a “leap of faith” (Kierkegaard) that grabs the audience’s attention and suspends their intuitive fear of electricity passing through the brain. Perhaps, heroic narratives set in homely magazines (such as *Reader’s Digest*) convince readers that ECT is not “so shocking” after all. It can be part of the everyday experience of being in the world. Similarly, Dr. Norman Endler in his memoir about ECT, *Holiday of Darkness*, simply skips out for ECT on his lunch break (Endler 25). Recovery from depression in both of these narratives appears easy and effortless, the patient just has to fall asleep—when they wake up, they have no memory of the treatment and their depression is simply “lifted.” He says: “A miracle happened in two weeks, I had gone from feeling like an emotional cripple to feeling well (...) my holiday of darkness was over (...) It was great to be alive again” (75). Endler’s lament at being an “emotional cripple” is interesting since he invokes a sense of not being able to navigate or attend to his moods (by using the derogatory term “cripple”) or being in “darkness.” Later on, in the next chapter, he still has no idea how to engage in a process of listening to his emotions after ECT. After his so-called miraculous recovery, Endler experiences a severe relapse and requires more ECT treatments, thus negating

the facile end to his “holiday of darkness”. Even though Endler strongly believes ECT cured his depression, his relapses prove that our emotional worlds are complex ecosystems within the body that hold unconscious information; they are not simply neurological areas of the brain or chemical reactions that can be physiologically governed. Emotions must be attended to and cared for like plants in a garden, no matter how difficult to cultivate. The idea of depression being “lifted” (extracted like weeds) instead of “worked-through” (like soil) represents the paradigm rift between the biomedical and psychoanalytic approach to mental health recovery. Relying on miraculous treatments (whether it be Prozac or ECT) erases the value of suffering as a teachable moment in our journey of postmodern selfhood.

The inherent value of this dichotomy is that it reinforces the idea of “normal” (as a neutral and emotionless state of being “balanced”) and the psychiatric profession’s ability to manage it. Virtually every form of human behavior has been classified within the normal/abnormal dichotomy and there appears to be no end in sight to the growing index of human dysfunctions, disorders, and diseases (...) the idea that some people are psychologically sick or disordered reflects the growth of the pathological approach, a distinctly Western and recent historical phenomenon in which it is assumed that personal problems are individual and caused by biological/physiological factors (Clark et al. 72-74).

The framing of ECT as a miracle is also a rhetorical defense, a way to regain public support for a treatment that went out of style due to human rights violations and its severe and debilitating side-effects (Burstow, *Psychiatry and the Business of Madness* 201-227). If language is a frame of perception that reflects invisible ideological formations, the trend of equating ECT with “miracle” seems to be part of the de-stigmatization campaign, a way of diluting the controversy to increase usage. This trend is ideologically tied to the goals of biomedicine as a

profitable, effective, and productive industry that can engineer happiness. Thus, the metaphor of ECT as a miracle is not without its sensational undertones that serve a specific class of people within the medical-industrial complex (namely those who profit from the sales and manufacturing of ECT machines), and ironically, at the same time, it conjures a certain hyperbolic grandeur that inevitably casts doubt on the validity of such curative claims. For instance, shortly before the publication of Dr. Manning's memoir, the cover of *New York* magazine on November 14th, 1994 reads "When Prozac Fails, Electroshock Works!" The assertive statement is juxtaposed with an image of a man's face with a strained and surprised expression in his eyes, a bolt of electricity jolting into his head, lifting his hair like a typical electrocution caricature. This image contradicts the promise of the title, or at least, it does nothing to calm public fears about the dangers of ECT. If anything, the article reiterates and reproduces the stereotypes it seeks to dismantle, ultimately adhering to fear tactics to sell a story. The caption on the next page reads: "It's still popularly feared and reviled. But these days—it's kinder and gentler—and widely used. Electroshock therapy is jolting thousands of patients out of suicidal depression" (Stone 55). The idea of being "jolted" or "shocked" out of suicidal depression is a violent one; even though medical journalist Gene Stone reassures his readers that modern ECT is "gentler and kinder," the only shift in clinical ECT procedures is the administration of anesthetics (Breggin, Burstow). Today doctors give better drugs to numb the pain of the electric shock, so it may be "kinder" initially, but the treatment is virtually the same as the 1940s.

Healing ECT's polemical depiction as torture device or miracle treatment goes deeper than reframing sensationalized cultural or medical representations; it is an emotional battle with contradictory subjectivities that must be attended to, and heard. As Donald I. Templer, a scientist

who investigated ECT's neurological effects and accusations of permanent brain damage, affirms, the reason why this treatment is so stigmatized is that "it is difficult to maintain an objective perspective because emotional undercurrents tend to run so strong" (95). To begin with, objectivity might be an impossible goal to achieve within psychiatry since it is intimately tied to interpretation of subjectivity and perception. Furthermore, the emotional stakes of ECT are highest for patients who risk losing (or have lost) integral aspects of their subjectivity, such as long-term memory (Breggin, Burstow) and cognitive skills, in the course of treatment. Equally emotional are claims by patients who frame ECT as a life-saving miracle (Endler, Nuland, Hersh). Without ECT, such patients believe they would not be alive today. Such powerfully charged statements require more than an "objective" measurement to honour the weight of their validity. They require space in which to resound as legitimate stories of distress and healing, even if they lose the capability to coherently think through the wound or events. In "Talking About the Unthinkable" Maria Medved and Jens Brockmeier discuss how people who experience brain injury (much like the type accounted by ECT survivors), go through a "shattering" of self and experience difficulty in narrating their perspective in a coherent way, which creates a horrifying disequilibrium. By the same logic, patients who experience rebirth or "miracle" recoveries also shed and forget aspects of their "former" selves (Johnson, Hersh, Nuland, Endler). Thus the narrative self, or identity, is a necessarily fragmented and broken concept, unstable and fluid within a postmodern context. Citing Goldstein's work on catastrophic reaction, Medved and Brockmeier describe the person's feelings after a "mental shock" as:

not only "inadequate" but also disordered, inconstant, inconsistent, and embedded in physical and mental shock. In these situations, the individual feels himself unfree,

buffeted, and vacillating. He experiences a shock affecting not only his own person but the surrounding world as well. (49)

“Objectivity” and concerns over empirical measurement methods are central concerns for re-balancing the inequality between scientific knowledge-production, medical discourse, and personal testimony related to ECT. Patients’ experiences of ECT need to be listened to from an intersectional perspective, one that considers the political economy of health and wellness within the ambits of power that regulate bodies into silos of sane/insane.

Maintaining objectivity in psychiatric metrics is another problem: the results of ECT are nearly impossible to measure since they simultaneously rely on patient testimony, psychological questionnaires, validity scales, and psychiatrists’ observations/interpretation. Burstow reflects on the seductive force of measurement-based information (i.e. MMPI tests) within the helping professions, because it appeases insecurities about the value/meaning of information, yet it can sometimes become an overused tool at the expense of reflective listening or empathy-based techniques. The tools used to measure wellness can even sometimes generate illness, she says: “traditional measurement theory assumes a correspondence between test scores and some existing reality. In contrast, the act of measurement may generate reality” (56). The ambivalence of recovery from depression and other affective disorders resists neatly defined terms of what it means to recover. ECT (and its discourse) does not take process, coping skills, social determinants of health, and long-term outcomes into account when it frames a “recovery narrative” around the therapy.

ECT Autobiographical Memory: Loss or Erasure?

The truth is that autobiographical memories are not possessions that you either have or you do not have. They are mental constructions created in the present moment, according to the demands of the present. (Ferryhough 6)

Should I acknowledge the fiction that I am (...) Bounded yes, but not by mortality, which is not what I fear, but by smallness, insignificance, which is what I do fear. The unlived life. Life in its hard shell safe from the waters above and the waters below. The home-and-dry life. Sound. Dependable. True? (...) There's no such thing as autobiography there's only art and lies. (Winterson 30-31, 69)

Despite its biomedical, yet miraculous (Peck, Endler, Fink) ability to bring depressed and suffering individuals "back to life" (Endler 75), the major ethical concern ECT poses for psychiatry is its impact on memory. The nuance between forgetting, memory loss, and what Linda Andre defines as "memory erasure" is a dangerous slip with ethical contours for considering how one narrates or recuperates, a life re-routed by shock. Wendy Funk describes ECT as erasing 32 years of her life: "I can't remember my kids, my career, my life prior to ECT" (Shrink Wrap CKLN radio interview with Don Weitz). Linda Andre, author of *Doctors of Deception*, says, "I no longer knew who I was" (9), recounting how ECT reduced her IQ from 156 to 118. In contrast to these accounts, the Diagnostic Statistical Manual (DSM) claims ECT to be safer and more effective than many antidepressants. The defining features of ECT's safety are contested by patient advocates, for instance, as Dr. Peter Breggin states, the terms "safe" and

“effective” are fictional at best because the FDA does not test shock machines (Breggin interview on CKLN radio). The medical community frames ECT’s “memory loss” as a normal and beneficial side-effect. In an interview with a local newspaper, Dr. Lance Patrick, professor of psychiatry at the University of British Columbia, names ECT “a therapeutic blocking of past trauma” (*In Defense of Shock Treatment*, March 10th, 1999, 10). Despite psychiatric survivors’ testimony of irreparable memory erasure, ECT usage is steadily on the rise. Critics (Burstow, Breggin, Weitz, Funk) believe this is because the shock industry is a very lucrative venture, and it is beneficial for the industry to have patients forget the harm done during the procedure. However, many psychiatrists claim there is no validity to electroshock’s memory erasure (Fink, Brodie). Norman Endler, in his memoir *Holiday of Darkness*, blames society’s negative attitude towards electroshock therapy on cultural representations of ECT resembling “gothic horror” (64). He goes on to say how *shock* is an inaccurate term to define the treatment since: “it does not produce a physiological, psychological or surgical shock. It is not traumatic. It is probably the most effective method for treating the affective disorders” (64). For Endler, too much information about ECT comes from film, literature, and magazines which obscures it as a “humane treatment” (65) there have been many clinical studies done on shock since the late 1970s (Breggin 6); they simply have not been taken seriously by the biomedical community. While Endler laments the erasure of electroshock’s clinical legitimacy, the canon of psychiatric survivor testimony claims it is the erasure of personal memories that need to be remembered.

The ethical contours of recovery under memory erasure demand a critical discussion of memory, trauma, and the value of remembering/forgetting. They also require differentiating between what is meant by “erasure” and how it compares to various understandings of “forgetting.” Examining psychiatric survivor testimony and life writing is useful in teasing out

the nuances, but first, I will engage in a critical discussion of memory itself. Memory is a “slippery phenomenon”—partly because no one is sure exactly what memory “is” beyond the metaphors used to contain its variations. However, it is useful to think about the metaphors used to describe memory, since it cannot be seen in and of itself: memory is a process, a phenomenon, a continuum in need of symbolization. We are never without memory, even when we cannot remember. As Edward Casey writes, “Even though we may misremember, there are few moments in which we are not steeped in memory. Every filter of our bodies, every cell of our bodies holds memories as does everything outside bodies and brains” (ix). To account for this overwhelming event, memory appears through its remainder: the representation that always fails to represent.

Ancient Greek philosophers struggled with metaphors to articulate memory’s ontology: from Aristotle’s “bird in hand” to Plato’s “bird in a cage,” memory shifted from something mutable and fleeing to something locked away and kept (Ricoeur). The Platonic “wax” metaphor has been a ubiquitous symbol of how memories leave traces, imprinted in our bodies and minds. Of course, memory is not a simple physical imprint, as theorists, writers, and artists have demonstrated. However, the struggle to “understand” and symbolize memory has continued for centuries. In 1953, *Scientific American* published “What is Memory?” in which author/scientist Ralph W. Gerard explicitly admits how even the sciences cannot agree on memory: “The means by which the brain stores the rich variety of human experience is completely unknown” (118). Gerard later defends a reductionist vision of memory, naming it a “smooth continuity” (120) that should be read in the broadest sense as “the modification of behaviour by experience” (120). To complicate this reductionist reading, decades later, phenomenologist Edward S. Casey declared that there is nothing consistent or enduring about memory; it occupies the unknown position of

the future in the present, while accessing the past. Thus, in the work of memory, the past is always transfigured in subtle and significant ways by transcending linear time. Casey writes, “Memory is already in the advanced position, always at work, continually going on, often on several levels and several ways at once” (ix). Thus “memory” is not something finite or “past”—it actively plays a role in keeping the present in contact with the past.

Memories are not shelved in our brains like books in a library, although this image, along with the “filing cabinet,” has been popularized by scientific, neurological and psychological discourse (Footnote). Groundbreaking psychologist and novelist Charles Fernyhough, in his recent book *Pieces of Light: The New Science of Memory*, stresses the danger of relying on metaphors that limit memory to the physical realm:

Metaphors of memory are overwhelmingly physical: we talk of filing cabinets, labyrinths, and photographic plates, and we use verbs like impress, burn, imprint to describe the process by which memories are formed. This view of memories as physical things is guaranteed to mislead. The truth is that autobiographical memories are not possessions that you either have or do not have. They are mental constructions, created in the present moment, according to the demands of the present. (6)

Thinking of memory in physical terms misrepresents the “time of memory” (Scott 33) believing it to be something that exists perfectly in the past, filed away in our minds and easily retrieved and consulted. This assumption of linearity and materiality would discredit memory as a recursive process, as something *made* in the present from past experiences. Memories are constantly happening, in motion, as spontaneous reconstructions from elements scattered through various areas of the brain. The latest brain research suggests that memories are more like

recursive “collages”, reconstructed, fragmented and jarring, instead of a coherent storage of information.

Based on memory’s epistemic insecurity, Richard Terdiman in *Present Past: Modernity and the Memory Crisis* discusses memory as a “problem” and a modern perturbation, resulting from traumatic political and social instability where the “coherence of time and of subjectivity seemed disarticulated” (3). More importantly, he troubles any stable definition of memory:

[M]ost often we think of memory as a faculty consisting of our consciousness and our self-awareness, as the means by which the coherence of our identity and our history is constructed and sustained. Such mnemonic activity is fundamental. But there is another side to memory—memory as a problem, as a site of cultural disquiet. (viii)

The “other side” of memory feigns unitary definition: the problem it presents is precisely its inability to rest in secure terms. While “memory” can be described as a “faculty” or a “phenomenon”—according to Terdiman, memory is a *problem* that struggles to be heard: ideologically, culturally, and beyond. It haunts all aspects of individual and social life, and it will not be silenced or contained. It is a silence that speaks and attempts to subvert historical master-narratives that persist in present-tense. This “crisis” echoes Frances Yates (1966) seminal text, *The Art of Memory*, where she radically claims: “we moderns have no memories at all” (2). Memory, once the poetics and praxis for knowledge-production, is obliterated, according to Yates: “We have not only forgotten what it is to remember, and what remembering is, but we have forgotten our own forgetting” (2). The depth of this repression for Yates is so devastating that memory, as responsibility and agency, runs the risk of becoming obsolete—downloaded, projected, and externalized onto machines. Thus, the ability to even define what memory “is” or

“can be” for beings is forgotten. Despite this anxiety, in Western thought, memory has been relegated as the foundation of subjectivity and collective identity formation. Memory is the fodder of knowledge-production—and by extension, its erasure has been used to conquer, colonize, and sustain cultural genocide. If memory is always/already unstable, fleeting and escaping us constantly—how can it be erased? Perhaps a more productive question is what do psychiatric survivors *mean* when they say their memories have been erased?

Many psychiatric survivors deliberately highlight the difference between “forgetting” and “erasure” in order to articulate how ECT was a form of violence against their selfhood. For example, Linda Andre’s seminal investigation and memoir on her ECT experience, *Doctors of Deception*, begins by teasing out the ethical contours of erasure, describing the phenomenon as “violent and unexpected” (2). Andre’s first chapter “The Trouble with Time” discusses the life events that have been obliterated from her consciousness post-ECT. She can only infer that these events happened based on the material evidence (photographs, books, notes, videos, etc.) left behind. Andre does not remember being an NYU graduate student in photography on a prestigious scholarship; she does not remember writing 24 scholarly articles for publication; she does not remember her wedding day; all of these events are remarkable enough that one would have some recollection, even if it was only fleeting. She says, “A period of time is wiped out as if it never happened” (2). Erasure, in this sense, cannot be linked to forgetting, because forgetting necessitates having a memory of what is forgotten. Forgetting is a productive and valuable part of memory; the two conjure meaning in an intricate semantic dance. Erasure denotes that the experience to be remembered never occurred, which would mean that Andre was never married, never published articles, or attended NYU.

Paul Connerton in “Seven Types of Forgetting” would qualify Andre’s experience as “repressive erasure” (60). He locates this form of forgetting “in the history of totalitarian regimes, where, as in Milan Kundera’s often quoted words ‘the struggle of man against power is the struggle of memory against forgetting’” (60). The condemnation of memory as a source of subversive power aligns with the struggle of many psychiatric survivors who attempt to historicize their trauma and abuse at the hands of psychiatry. Erasure is thus an attack, intentional and geared towards obliterating potential evidence. More deeply, it is a deletion of one’s selfhood or aspects thereof: as Andre writes, “You didn’t just lose your suitcase; you can’t say where you got it, what it looks like, what you packed in it, what trips you’ve taken it on. You don’t know you’ve ever had it” (2). In this case, Andre distinguishes “loss” from “erasure,” saying that if something is “lost” you can recover it because you can still imagine it, and “the fact that it ever existed at all is not lost to you” (1). Echoing Andre’s sentiment, GraceAnn Inyard laments her selfhood post-ECT in the *OFF Center* newsletter:

And my brain was thick with fog and confused, thoughts were vague, incomplete, and I was always feeling as if there was something important about to be remembered...

(But what?)

I had been told, so they tell me, that the shock treatments would cause some memory loss for a short time. Now years have passed, and I’ve since discovered that the memories simply got destroyed—like a swipe of an eraser across the chalkboard, leaving vague traces of what was once present or blackness. Whole

years are gone, large gaps in my personal history, and what memories remain are out of chronological sequence.

(How did I become who I am now? Who was I when I don't remember existing?)

And I find myself mourning the death of my self, for I am not who I was, for I am not who I would have become had my memories/existence not have been erased or rearranged

(...)

But here I stand, wearing someone else's body, which contains someone else's half-blank mind (...) So, *this* is me? (15)

The imagery of an eraser swiping a chalkboard evokes Inyard's inability to retrace (or rewrite) the parts of herself that were once readily accessible. The fragility and ephemerality of memory are also conjured in this image. "Who was I when I don't remember existing?" is a powerful question. She has become a stranger to herself, not only in an existential sense but in a literal corporeal sense. Her body is no longer her own. She occupies it like a tourist in a hostel, a transient resting place that she could never call home. What Inyard has lost is irretrievable—it has been utterly destroyed. The traces left behind no longer resonate, nothing can be remembered or put back together into a narrative coherence. She is met with disbelief, doctors who tell her that her disillusionment is part of her "illness" (15). For both Andre and Inyard (like countless others), the experience of disorientation after-ECT is traumatic. It feels like a wiping out of their existence, thus classifiable as "memory erasure." Evelyn Scogin in her memoir *Descent* has a similar description of the difference between "memory loss" and "erasure," which she equates to mourning a death of selfhood:

This type of loss is much more and not simply because a memory is gone. It's as if that entire time frame never even existed. Something more fundamental is lost because it involves not only whole periods of time but also erases all feeling and sensations, all connection of anyone or anything for that part of your life.

For me, it felt and continues to feel as if I never existed for that period of time.

(...) I feel afloat in a dark space where I have no sensations, no substance at all. I don't know how else to explain it to anyone who has not undergone such a profound loss of self. (135)

Scogin was given ECT to prevent suicide and self-harm after having been heavily medicated with no improvement—she continued to have suicidal ideation after ECT (134). The irony is that the treatment's erasure almost satisfies suicidal fantasy to “never have existed.” If suicide is the desire to take one's life, to no longer exist or never have existed, then, according to Scogin, ECT's “memory erasure” succeeds in fulfilling that morbid goal. She purposely describes the loss as something “fundamental”, more fundamental than memory itself. She laments a loss of sensation, perception, and the ability to relate to others—which seems like her fundamental humanness. Thinking back to ECT's claim to be “life-saving”, and a miraculous cure for high-risk suicidal depression, one must consider what it means to recover from distress if one form of continuous pain is simply replaced with a new form of ongoing torment.

Conversely, erasure takes away one's capacity to engage in the imaginative, narrative-process of remembering—of creatively amassing fragments of the past into a present context or “story.” In some ways, Andre is not so much concerned that she does not remember things correctly (as sometimes is the case with memory loss or amnesia); she fears that she cognitively cannot be *creative* enough to remember her life. At the core, what she is talking about is her

inability to imagine. According to Andre's account of erasure, if memory is a creative process, shock destroys that creativity. Ernest Hemingway, shortly before committing suicide, wrote "What these doctors don't know is about writers (...) what is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure, but we lost the patient"⁹ (*Papa Hemingway*). Memory for the artist, and especially the writer, is the basis of all their creation—it is where they can re-assemble parts of their lives and embellish with fictive elements, so that what they create can ring true to their audience. Memory and imagination are intrinsically linked; before we translate our memories into language, we imagine a scene in our minds and conjure elements of the past through what Sartre defined as the "magic" of fantasy. Accordingly, memory's low status as a mental faculty comes from this blurring of fact/fiction, or false consciousness, which memory has no guarantee of assuaging or preventing.

As Paul Ricoeur reminds us in *Memory History Forgetting*, there is always/already the trouble of articulation and perception within memory/forgetting. How does one articulate what they perceive accurately? Does "accurately," mean, as Plato puts it, to copy an original "true-thing" that precedes it? This would require memory to conjure a faithful resemblance to "the anteriority of marks" (Ricoeur 12), which would more likely become a "mask instead of an exploration of the truthful dimension of memory" (Ricoeur 13). There is always the risk of making mistakes because all we have are impressions that only skim the surface of the past. Re-reading Socrates' *Theaetetus*, Ricoeur recalls this problem as it is figured in the metaphor of the wax imprint. Socrates positions memory as a sort of "wax in our soul" where whatever is impressed upon the wax we remember and know so long as the image remains in the wax.

⁴ Ernest Hemingway, talking about electric shock therapy, as quoted by author and confidant A.E. Hotchner in his book "Papa Hemingway." in Sandy Rovner's "The Electric Shock Debate" *The Washington Post* January 30th, 1985.

However, this poses the problem of memory and forgetting, because there is the messy transition between the moment of perception and the moment of recording the imprint. Before we imprint it, the representation must forget. This implies that we must forget to remember, yet one can make a mistake between the two. As Ricoeur reminds us of Socrates' phenomenology of mistakes—the act of taking one thing for something else—and remembering falsely. He grounds this “falsehood” in the deception of the wax impression: “The mind applies the imprint of the absent perception to the perception that is present; the mind is deceived in such an instance” (Ricoeur 9 qt. Socrates 194a). Socrates asks, “Can a man who has learned something not know it when he is remembering it?” (Ricoeur 7). This is different from forgetting as Ricoeur sees it, for it is not a denial or unconscious burying of knowledge, but rather a sudden non-knowledge—more like making a mistake. Just as much as “remembering a memory may not make it true” (10), it does not demote it from the realm of knowledge that one keeps and possesses. This is where the metaphors shift from wax to birds. Here, Ricoeur makes a distinction between *possessions and keeping* by using Socrates' metaphor of the bird in the cage versus the bird in one's hand. This shift in metaphor suggests the transition from passive to active memory. A bird in hand is free to fly, to return or never come back to the hand that holds it. The relationship is one of openness and freedom, illustrating a knowledge that does not limit itself to certainty. Instead, it is a knowledge that maintains doubt and anxiety. Conversely, the caged bird is restricted and symbolizes the knowledge we possess, know, and retain. By illustrating how memory is an active search for an image that once was, there is an ethical dimension added to memory: it is bound by its relation and responsibility to act upon the past. On the other hand, imagination is boundless, moving toward unforeseeable futures without the same responsibility to remain faithful. Imagination can provide a creative discourse that flirts with ideology and

utopia and allows one to express aspects of the world and experience beyond that of ordinary, descriptive language. Objectively, memory might fail us, but we have nothing better to know that something happened.

Andre's memory metaphors may be inaccurate, but they help her symbolize what has been destroyed: the narrative capability to articulate oneself, to claim one has existed. For instance, when she equates memory to a suitcase as if it were a container that allows one to collect and carry fragments of the past intact, she objectifies memory, limiting it to the physical world of the finite. However, her claim of erasure (the lack of imaginative and cognitive abilities post-ECT) has been shared by other women. Susan White in "ECT: A Victim's Reality" discusses her frustrated speech and impoverished sense of narrative "selfhood": "Everybody that I come into contact with knows more about me than I do and this makes me feel inadequate, confused, very frustrated and angry about my loss. Now knowing who you are and not having a 'sense of yourself' is a very real part of my everyday life!" (4). Being lost within their own bodies, homes and neighbourhoods extends to the metaphor of an existential homelessness. Without memory, we are lost to ourselves and cannot inhabit the world with others in meaningful ways.

Reclaiming the erasure of psychiatric survivor histories is part of the activism at the forefront of Janet Frame and other survivors' narratives. Re-membering as a narrative project of reassembling old wounds toward new and more integrated interpretations may be a key feature of one's recovery process. Dr. Bonnie Burstow talks about the need for her clients to remember in order to recover. Memory erasure, she claims, puts her clients at a disadvantage for recovery: "When the past is taken away the person cannot function properly as a meaning-making human

being.”¹⁰ They lose the ability to navigate the world and relate to others. Traumatic memories that re-occur and torture individuals with episodic flashbacks are key symptoms of Post-Traumatic Stress Disorder. The survivor will sometimes disassociate and “forget” or repress certain memories because to remember is too painful and causes serious physical stress. ECT is not a precise memory deleting machine. Forgetting can be a necessary part of recovery as well; however, erasure is more deeply rooted. Perhaps trauma survivors would want their trauma to be erased so that they could live as though it never happened, but unfortunately, ECT cannot guarantee that the problematic memories will be gone when they wake up. Although I do not necessarily agree with the anti-psychiatry statement that “memory is sacred” (CAPA slogan 2008), the creative capability to narrate and weave memory into a coherent and meaningful representation is an important part of one’s recovery journey and should be nurtured. We cannot assume that memories are inherently good or bad or that they contribute to a stable sense of self; they simply help us navigate the world with some sense of orientation and confidence—while maintaining a healthy amount of doubt that allows one to question what they perceive as “real” or “true.”

Referring back to Leigh Gilmore’s notion that trauma is the limit-case for autobiography because it escapes representation, often protectively buried within the subject’s unconscious, there remains something inexpressible in the story of ECT. As Ricoeur writes, “The limit facing the historian—just as for the filmmaker, the narrator and the judge lies elsewhere: in the intransmissible part of extreme experience” (452). Demanding a turn toward the reparative

⁵ “Electroshock and Women” *Shrink Wrap* Host Don Weitz. CKLN Toronto, September 19th 1999 (retrieved Psychiatric Survivor Archives of Toronto). Radio.

possibilities of memory to excavate voices and utterances of suffering, those long-buried in an epistemic abyss, Ricoeur proposes an ethics and therapeutics of memory to *act* upon the work of history. Namely, Ricoeur seeks to engage in dialogue with a history constructed out of the poetics of narratives. He seeks to use memory and forgetting on the narratives that remain unquestioned and taken for granted, the narratives that overwhelm, or that remain incomplete and lacking in slant. What Ricoeur proposes is for the work of memory to provide an interruption and allow silence and forgetting to speak with historiographical discursive practices. Ricoeur reminds us that, contrary to what might seem like the work of memory, to remember is intimately bound to forgetting. Can we bear to know this history to remember it? Must we forget it first? As such, the limits of historical representation have to do with a capacity for reception on our part. How to represent the unrepresentable stems from therapeutic as well as epistemological concerns. The demand for truth in such extreme cases should be seen as closely tied to what Freud called the “work of mourning” (156) along with the work of overcoming the process of resistance to this work. How does the test of the impossible speak to Ricoeur’s interest in finding a way to reroute the opposition between memory and forgetting at the limit of representation within the ECT canon?

On the other side of the miracle/erasure debate, the biomedical claim that memories will return weighs in to discredit survivor testimony and promote the treatment as “safe and effective”. “Oxygenation” has been claimed to reduce memory side-effects (Shorter, Endler). Most psychiatrists will not use the language of “memory loss” or “erasure” to describe side-effects; rather they use medical terms like “retrograde or anterograde amnesia,” which showcase a veneer of objectivity and neutrality. In the memoir *Perfect Chaos: A Daughter’s Journey to Survive Bipolar*, Linea Johnson and Cinda Johnson describe their fear of ECT and memory loss.

Linea is a prodigy pianist, studying music in Chicago, and relies heavily on her cognitive abilities and memory to achieve her goals. Her entire identity is based on her musical talent and skill. Being diagnosed with bipolar disorder is a huge challenge for Linea and she goes through several life-threatening “manic” episodes. ECT is used to “extinguish” (181) her mania. Although ECT causes extensive memory loss and damage, Linea remains “thankful” (301) to be alive, even if her music career was put aside she finds joy in “educating” others about ECT:

(Linea writes) You know, everything just kind of ran together before. Now I hear the spaces. Things were kind of gray. No shadows of anything. It is like things are sharper to me now (186) (...) Levels of acceptance come and go. I still get angry and fight and kick and throw temper tantrums over the fact that I will have to go through these ups and downs from time to time. I still get sad about the fact that any of it happened in the first place.

(...)

(Linea’s mother writes) –Linea had never veered from her goal of excelling in the world of music. For her to let go of all the years of work and commitment had to be so difficult for her. (...) Her commitment to others and her articulate and brilliant voice have opened doors for people to understand and embrace an illness that is common to so many families. (301-319)

Linea can listen better thanks to ECT—sounds are “sharper” (186)—so it can be argued that ECT enhanced her cognition and brought her out of the depressive murkiness. Becoming the “good patient” who welcomes treatment and follows doctors’ orders is the underlying theme of the memoir. Linea comes to terms with ECT and learns to accept her need for it—she becomes a spokesperson and engages her “lived experience” as grounds to promote the treatment. She

complains about losing memories (like her grade 2 birthday party), but in the grand-scheme of things, she does not mind, the familiar rhetoric of miracle cure prevails, she ultimately adheres to a certain discourse. Besides its impact on memory, one of the major controversies within the ECT debate is its disproportionate usage on women (Dukakis and Tye 14). While psychiatrists are quick to meet gendered observations with statistics of women being more depressed than men (Dukakis and Tye 14), they do not factor in socio-economic, systemic, or gender-based oppression within those numbers. Dr. Bonnie Burstow in her article, “Understanding and Ending ECT: A Feminist Imperative,” believes gender oppression is an operative aspect of the disparity. She boldly states “ECT is a form of violence against women” (115), and reveals insidious mechanisms of misogyny within the mental health system using institutional ethnography and empirical research.

Psychiatrist Dr. Peter Breggin’s research also investigates the gender dynamic of shock, writing that it is “currently being done to elderly women...because they are the least likely to complain” (Breggin 10 Simple Truths about Psychiatry). The Ministry of Health in Ontario (Breggin citing Weitz 7) reports that 71% of patients given ECT in hospitals are elderly women. Furthermore, the pro-shock argument that women are more depressed than men does not hold up when considering “the electroshock therapy review committees found women are electroshocked two to three times as often as men irrespective of diagnosis” (Burstow 117). One of the women Burstow interviewed stated, “It can feel like a brutal assault on who you are” (46), thus emphasizing the psychological, emotional, and physical violence of the procedure. Elaborating on the shift in psychiatry from a psychoanalytical to a biomedical paradigm, Breggin describes how female patients are rarely listened to by psychiatrists today. Instead, they are diagnosed, drugged, and told that maybe a social worker will talk to them (Breggin). At the core of this

debate is the silencing of women's voices, identities, and narratives of suffering through a denial of listening and care.

CHAPTER 2: *Madness Cannot Speak and the Ethics of Listening Otherwise in Psychiatry*

Madness Cannot Speak

Madness exists beyond language in the silence of infinite, nebulous possibility: it “exists at the limits of our world” (Foucault, *History of Madness* xxviii). A Renaissance term that predated biomedical terminology, “madness” was primarily used to describe religious experience, perception into other worlds or dimensions of time/space. Madness was a menace to the organization of human civilization and culture that was burgeoning after the dark ages (Foucault). Despite the history of madness, the objectification of people who display mental difference continues today. Madness remains the unspeakable family secret that has been locked in the attic of history, and cannot be explained sufficiently to calm prejudice and fear. Madness as metaphor is not something that can be cured: it resists science and contests reason, which is why it was abandoned by medicine, and the metaphor was thrown out when clearer and more refined psychiatric language emerged to explain distress. Despite its banishment from medical epistemology, madness has never left cultural representations and memory: from literature to philosophy to activism, it speaks both a beautifully and monstrously subversive language meant to incite inquiry into illusorily incontestable norms.

Madness Speaks

Psychiatric survivors/service users have spent over 60 years reclaiming madness, advocating for human rights, system change, and improvement (Mendolia et al. 8). Most importantly, they have asked to be listened to on their own terms, to be liberated from psychiatry’s language and epistemology. Mad activism goes as far back as the 1960s, around the time that Janet Frame

wrote *Faces in the Water*. From service delivery to hospital policies and provincial legislation, some of the core values grounding activist leadership have been (and continue to be): human rights, equity, dignity, choice, self-help, self-definition, and self-determination (Mendolia et al. 9). Early advocacy spawned a new era of language to reclaim madness as a source of creative power.

The Mad Pride movement, which emerged in Parkdale during the late 1970s and 1980s post-deinstitutionalization, served to free madness from metaphors and to ground it in social, economic, and political practice and human rights. The movement reclaimed madness from pathology to reframe it as epistemology and consciousness. *Phoenix Rising*, a Toronto magazine, emerged during this time, documenting testimonies of discrimination and rights violations that psychiatric survivors and former patients faced, both inside of institutions and in social life after their closure. This publication was a foundational pillar in advocacy and the consciousness-raising movement of Mad Pride: “*Phoenix Rising* helped forge the beginnings of an accessible and very public critique of psychiatric practices” (Costa, *Mad Matters* 197). This public critique influenced the formation of the Psychiatric Patients Advocates Office in 1984 (*PPAO Report* 1994, 5). Patients were finally able to vote, and significant strides were made for disability and psychiatric rights.

Mobilizing one’s testimony of abuse or human rights violations was key to the ECT-survivor advocacy movement, yet it was a struggle for their testimony and lived experiences to be heard and legitimized within mainstream public discourse. In the 1980s and 1990s coalitions like the World Association of Electroshock Survivors, the Committee for Truth in Psychiatry, and Coalition Against Psychiatry were actively engaging in public discourse about the representation of ECT as “miracle” in the media, human rights trials, and inquiries into patients’

deaths while in hospitals, but they were ignored. Many activists were motivated by their own experiences of harm after receiving ECT and its impact on their memories.

Mainstream discourse supports an “evidence-based” perspective that only counts one kind of evidence: as Funk names, thousands of survivor testimonies are completely ignored, silenced, and rendered invalid, even in talk shows for the general public. Wendy Funk was not going to be silenced. She wrote hundreds of letters in response to representations of ECT in popular media, from movies to talk shows, and demanded survivor voices to be equitably represented and brought into the public sphere for a more well-rounded debate, one that would respects the accounts of “memory erasure” that were being systematically erased from history and society’s collective consciousness. Even if she might not have succeeded in changing the tone of media representations of ECT, given the current trends we see in popular journalism today, her work did lead to an epistemological questioning of what counts as evidence and bias in psychiatric and pharmaceutical research (Burstow, Breggin, Weitz).

This movement of collective survivor voices and advocacy for system change spawned a new field of academic inquiry named Mad Studies, associated with Ryerson University in Toronto, which grew out of Critical Disability Studies. Mad Studies seeks to develop new epistemologies to understand experience outside of the empirical/scientific model or medical model. Lucy Costa offers the most comprehensive definition of Mad Studies I have ever read:

an area of education, scholarship, and analysis about the experiences, history, culture, political organizing, narratives, writings and most importantly PEOPLE who identify as Mad, psychiatric survivors, consumers, service users, mentally ill, patients, neuro-diverse, inmates, disabled; to name a few of ‘identity labels’ our community may choose to use. Mad Studies right here, right now is breaking new ground. Together, we can

cultivate our own theories, models, concepts, principles, hypotheses, and values about how we understand ourselves, our experiences in relation to the mental health system, research, and politics. No one person school or group own Mad Studies or defines its borders. (271)

Mad Studies owes political and methodological allyship with Disability Studies, Women and Gender Studies, Queer Studies, Black Studies and critical activism. Mad Studies discourse is significantly rooted in standpoint theory, a feminist perspective coined by Sandra Harding which argues that knowledge stems from social position. Standpoint theory denies that scientific knowledge is objective and suggests that research and theory have ignored the perspectives of marginalized people. The work of Dorothy Smith was foundational to this theory. She claimed that women's everyday experiences are fertile ground for researchers to ask new questions for more meaningful inquiry into sociological issues. Harding writes that "scientists have ignored their own androcentric and sexist research methods and results, despite the claims of neutrality" (Harding 438). Applying standpoint theory to Mad Studies emphasizes that psychiatric language and methods are not inherently pure or neutral: they are constructed as such. The term Mad Studies was first coined by Canadian activist Richard Ingram in 2008 when giving a talk at a disability conference, and it grew into a Ryerson University course developed by David Reville and Kathryn Church called "Mad People's History."

The aim of Mad Studies is to dissect and unveil psychiatry's underlying bias, assumptions, and ideology. The necessity of seminal anthologies in Mad Studies include *Mad Matters: A Critical Reader in Canadian Mad Studies* (2013), *Psychiatry Disrupted* (2015) and most recently, *Madness Violence and Power* (2019) have contributed a foundational body of disciplinary work. These texts contextualize Mad Studies as a "project of inquiry, knowledge

production and political action.” This three-pronged approach is important to remember when thinking about contemporary “patient engagement” mandates which exclude or gloss over political dimensions. An important contribution to epistemology by Mad Studies is the observation that while truth claims of mainstream mental health thinking rest on privilege of method, behind them are a set of ontological assumptions about what madness is, how it comes about and how it should therefore be treated. Unlike psychiatric survivor research (or survivor-research) Mad Studies is less tied to the medical model (Faulkner) and it attempts to move away from essentialist rhetoric that traps knowledge within “identity politics” and the myth of authenticity. The underlying message is that people can reclaim madness as a source of knowledge: “it is not just about ‘experiential knowledge’ but about politically situating our knowledge in relation to other sources of knowledge and in relation to our strong history of survivor research” (Sweeney 38). This counter-narrative interrupts the smooth history of psychiatry and biomedical knowledge as a neutral endeavor.

Mad Studies has its flaws; namely, it is a predominantly white-centered field. However, many scholars have advocated for critical theory to be meshed into its discursive analysis to ensure that space is being made for racialized members of mad communities to speak. Mad Studies must “challenge the white-centered core of survivor knowledge and research” (Le Francois, 2015). This field of inquiry brings mad voices to the academic table, yet these voices are still competing against a hierarchy of knowledge dominated by the sciences. Mad Studies is also critiqued as impractical because it leans towards theory vs. praxis, and as such, does not subsequently tend to the material realities of madness in capitalist society. There is space to meet these critiques with the tenets of Mad Studies outlined in *Mad Matters*: rhetorically, at least, there is a declaration of intersectionality and praxis as the core mandates of the discipline.

Despite the strides made by advocacy, madness remains an invisible and silent category. What is popularly imagined as “mad” suspends everything we thought we knew of the observable world; it seems supernatural, above and beyond anything that could possibly be recognized as human. As Nature is not a natural concept but a concept of reason (Kant), madness is thus irrational and overly primitive, tied to an untamed and primordial existence beyond socially constructed time. Yet its chaos reinforces the subtle “order of things” (Foucault) that governs curated knowledge which we take for granted: all that has been naturalized around us by culture, reason, and civilization. Foucault’s seminal work *Madness and Civilization: The Invention of an Idea* and *The History of Madness* deconstructed the disciplinary role of psychology, a modern vector of power that naturalizes subjectivity/individuality as Euro-centric, white, masculine bodies. He was hoping to question the “calm knowledge we imagine we have of madness” (Foucault 23) to disrupt the rational/irrational dichotomy produced within modern society. When Foucault implies that madness cannot speak, he means that people who have been labelled “mad” cannot be heard, or listened to, as valuable contributors. They are always/already speaking as mad, and cannot be trusted with being able to perceive the world in an accurate or coherent way. Their perception is invalid, thus any attempt to articulate what they see, hear, feel or understand about their existence is taken as a symptom or proof of their madness (or illness). This devaluing is named as epistemic violence by those who have reclaimed madness as a source of valid analysis.

Foucault’s seminal work has inspired interdisciplinary scholarship and praxis in which a merging of the “medical” with the “human” can take place: medical anthropology, medical humanities, critical psychiatry, narrative psychiatry, community psychology, critical disability studies, and mad studies (to name a few). This subjective “turn” in the medical field has

prompted innovative and timely programs and projects that seek to meaningfully engage the voice of lived experience toward system change. In my conclusion, I unpack the ethics behind these seemingly benevolent gestures of inclusion and position them as “ethical domination” (Voronka 33). Even though these projects aim to listen to people who have suffered mental health challenges and addictions in ways that were never thought possible during the asylum era, they now possess within them a new kind of danger: neoliberal ideals of self-sufficiency and productivity.

Returning to Michel Foucault, the notion that madness cannot speak (*The History of Madness* xxviii) is particularly compelling for psychiatry’s ideas on listening to “find the patient” and policy-makers newfound interest in engaging the voice of lived experience within the “engagement enterprise” that co-opts Mad history and analysis (Costa, Voronka). To be *mad* is typically characterized as someone that speaks “out of order”, who speaks when they are not meant to, defies grammar and expresses emotions that are far beyond the limits of social conventions—then how can they be listened to ethically, without the diagnostic reading of their speech? Furthermore, when it comes to stakeholder engagement for quality improvement projects, what does listening to “the voice of lived experience” really mean? Voice must always be understood as plural, even at the cost of grammar, because our identities are fluid, incoherent and constantly evolving. Therefore, the expectation of a representative “voice” that can speak eloquently on behalf of a diverse and heterogeneous group of people who suffer from mental health challenges is inherently tokenistic.

Psychiatric listening is diametrically opposed to ethical forms of listening. Psychiatric textbooks describe listening as “finding the patient” (Mohl 2), The “commonplace” (Felman 13) of madness, as Shoshana Felman describes in *Writing and Madness*, is worthy of attention

because it subverts modernist attachments to certainty, to what can be knowable and self-evident: “It has caused the verb ‘to know’ to be put in quotation marks” (13). Felman argues that madness is now culturally abundant and over-represented and that “we are experiencing an inflation on the discourses on madness” (13). The normalization of madness creates a paradox, a collapse between the inside/outside of what is taken to be culturally expected as “mad.” Felman says, “Madness usually occupies a position of exclusion; it is the outside of a culture. But madness as ‘common place’ occupies a position of inclusion and becomes the inside of a culture (...) it is inside, paradoxically, to the extent that it is supposed to be the outside” (Felman 13). The ambiguity that madness offers between insider/outsider culture, the blurring of lines between the aesthetics of madness and the lived experience of mental illness/disability, is troubling. The co-optation of “mad speech” and social justice posturing could potentially dilute people’s lived experience of mental health issues and trauma. Madness is not a metaphor, even while it is strategically used as such.

In Foucault’s project, the metaphor of madness is to be excavated and described as it was before science conquered it with language. The pre-scientific history warns of how madness might turn to ashes and be forgotten. He writes how the object, and even the possibility of madness, “will close upon itself and the traces it will have left will no longer be intelligible” (Foucault 541). The doom will be its ongoing silence that forgets it ever existed, and how future generations will be not able to learn from madness because it will not make itself known. Linguistically speaking, the word madness is already obsolete, replaced by mental illness on the mental health spectrum. Thus, what worries Foucault is the silencing effects of discursive practices that make us forget a history that has led to current abusive psychiatric practices and an inability to think with madness:

The familiar game of gazing at the furthest part of ourselves in madness of lending an ear to those voices which from far away tell us most clearly what we are, that game, with its rules, its tactics its inventions, its ruses, its tolerated illegalities will forever be nothing more than a complex ritual whose meaning will have been reduced to ashes. (542)

The further voice we hear might be the most familiar, but remains something we *think* we hear. It forces us to doubt what we think we know, and leads us to believe that it may be easier to simply not listen, to pretend that we cannot hear ourselves in others. In this case, madness may even reinforce our fictions of sanity, or at least, our fictions that sanity is opposed to madness.

On its own, sanity lacks shape, definition, and solidity: there are no accounts of sanity, no testimonies of its lived experience. In *Going Sane* Adam Phillips attempts to describe sanity, a concept that is not clearly defined in our culture, despite so much depending on its existence: no one knows what it means beyond the “absence of madness.” For Phillips, sanity is an ethical responsibility and nuanced form of courage that fosters quality relationships, essential for the “good life,” a life where everyone can live well (i.e. suffer well) within caring, loving and compassionate environments where they are listened to. Sanity is the courage to confront one’s monsters, one’s suffering, and to be an active agent in social change. To further elucidate his thinking, Phillips distinguishes between “superficially sane” and “deeply sane”: “For the superficially sane, sanity means a life without conflict, a life of relative peace, a life without malice or greed” (180). To be deeply sane, as Phillips suggests, is to be able to hold onto one’s madness in such a way that it can inform one’s wisdom:

For the more deeply sane, whatever sanity might be, it is a container of madness, not a denier of it. (...) His sanity is both the cause and the consequence of not having

conformed, of discovering his true nature through a refusal to comply. (...) The deeply sane accommodate their desire to the needs of others. (180)

Philips' imagining of sanity as a container for madness is hopeful; it holds space for madness to speak. In a sense, to be "sane" is to be able to *listen to* one's "mad speech", the monstrous world of suffering and fear, which we all return to when confronted with traumatic life events or simply vast chasms of the unknown. At the same time, to be sane is to be validated and listened to in the broader social world. Philips describes the "deeply sane" like tragic heroes who have survived their ordeals (181) and can describe what they are "made of" (181). They are not skimming life on the surface; they are deeply connected and civically engaged. Unlike the vapid and empty form of reassurance that keeps us complacent and "safe", this kind of sanity awakens us and forces us to act in new ways. Contemplating how madness cannot speak, psychologist Gail Hornstein asks how we could listen beyond our desire to know exactly what someone is trying to say. Could there be space for the ambivalent within psychiatry? Hornstein thinks that listening to madness, as is, might help us understand behaviours that seem outside of reason. It may reveal implicit coherence, a *raison d'être* that needs acknowledgment and welcoming, while forever being out of our grasp:

Can we possibly understand people who decide to throw themselves under trains or any other strange and anguished things that being 'out of your mind' can bring about? Might the accounts that crazy people give of their own actions actually help us grasp them? (156)

By learning to listen beyond diagnosis, psychiatry can play a very special role in medicine: it has the opportunity to gain insight into the complexity of distress in an intimate way and to help build capacity for the voices of people with lived experience of madness to be integrated into the

mental health system and towards change. Psychiatry can listen in multiple ways, from the hermeneutical to the ethical and exact-empirical. It can do more than simply “find” patients; it can leverage their stories of distress and empower people to make coherent meaning out of loose ends, while at the same time helping them deal with their symptoms. Perhaps, to be able to listen, psychiatry needs to come from a fundamentally different paradigm, one that does not see sanity in opposition to madness. As disciplines like Mad Studies and Critical Disability Studies attempt to move beyond the binaries that have separated the subjective experience from the medical, according to Phillips, sanity is merely the act of recognizing our humanity, the constant reassurance we need to believe we are still human despite the decay, violence and suffering around us:

Sanity is the project of keeping ourselves recognizably human, therefore it has to limit the range of human experience. To keep faith with recognition we have to stay recognizable. Sanity, in other words, becomes a pressing preoccupation as soon as we can recognize the importance of recognition. When we define ourselves by what we can recognize, by what we can comprehend, rather than say, by what we can describe, we are continually under threat from what we are unwilling or unable to see. (141)

We are terrorized by our blind-spots, by what we cannot accept within ourselves. Thus, deep sanity, much like deep listening (Voegelin 2), is closer to ethical gestures because it is also composed of communicative meaning-making, the ability/privilege to speak and be heard. Being able to describe what one is “made of” and articulate one’s perspective on traumatic experiences is diametrically opposed to being diagnosed for what one lacks or what one cannot enunciate coherently.

The “good intentions” of psychiatry to diagnose with the aim of curing or “finding” (Mohl 2) their patients are not helpful if they silence someone seeking love, compassion and listening. Not being listened to is what prevents madness from speaking. Building upon the words of Winnicott, Philips claims that “madness is the need to be believed” (178): it is the result of not being recognized or of not being validated. The lived experience of not being *listened to* runs deep for many psychiatric survivors. They have mobilized for decades (Mad Pride) to be legitimately heard within civic spaces, outside of psychiatric confinements (both physical and discursive). Mad Studies scholars have taken up and subverted Foucault’s statement that madness cannot speak in many ways. They have proven that “madness” can indeed speak, and it is time for the mental health system to listen to its counter-discourse:

Medicalized individual models of mental illness have dominated all aspects of madness and distress in the Western world since the 18th century Enlightenment. Over the years, they have increasingly been exported to colonize, subvert or overshadow other cultural and societal understandings and interpretations of these fundamental human experiences (...) that is why this book is so timely and so important. It provides a counter-discourse that is desperately needed in our times.

It is a counter-discourse, which like the social model of disability of the international disabled people’s movement, does not seek accommodation or understanding from dominant traditional medicalized understandings, but instead seeks to confront them head-on and provide alternatives that offer positive promise for the future. (LeFrancois et al. ix)

The genealogy of madness that Michel Foucault traces in *The History of Madness* is not one that speaks for itself but is articulated through institutional discipline within which the voice is silenced under the weight of authority: the Church, the Law, the Hospital. Disciplinary listening is what psychiatry excels at. If therapeutic communication relies on the psychiatrist's understanding as a conquest over the patient's irrationality—such understanding is necessarily false—one devoid of ethically listening to the patient's subjectivity and difference. The psychiatrist's "difficulty" in this communication is tied up in a need for recognition. Moreover, can understanding even be possible if it is forced or expected? The *Lippincott's Psychiatric Nursing Manual* defines the "therapeutic relationship" as a pursuit of understanding that leaves no room for uncertainty or affect. This relationship is founded on "planned and structured psychological, psychosocial and/or interpersonal intervention aimed at influencing the behaviour, mood and/or emotional reactions of a mentally ill patient". Thus, the framework and structure of such communication regularizes speech between patient and nurse into "productive" timesaving streamline coherence. As the manual proclaims: "We are looking for the best framework with which to frame the subject in order to understand and interpret the symptom" (46). Such "frameworks" reflect Foucault's discussion on the medical gaze as a constraint on the patient's subjectivity. What happens to madness in this therapeutic framework? Does "madness" as historical subject-position disappear under the standard statements of "therapeutic communication"? Here we see how psychiatry's pseudo-objective stance on mental illness intervention lacks "truth", or rather a self-reflexive relationship with the historical, discursive, and representational construction of madness. According to Foucault, "true psychology should respect madness" (*Madness: The Invention of an Idea* 56) and learn how to speak with it, through discursive time and space.

Foucault predicts the end of madness with the words, “One day perhaps we will no longer know what madness was” (Foucault 541), and from a historical perspective, he writes of its complete disappearance due to sophisticated modes of neutralization that have “removed the face of madness” from Western culture. Removing the face of madness means to dehumanize its expression, to render people labelled “mad” as pathologically, biologically, and morally inferior. Thus, when Foucault eludes to madness cannot speak he means the patient as a “person” is forgotten and erased from the equation of biomedical listening; their body is emptied of all emotion, will, and soul. The very notion of “care” becomes an absurd concept, a sort of joke that no one laughs at. Psychiatric/medical students read textbooks that define caring relationships, but in practice, they are rarely able to live up to those textbook standards (due to downsizing cutbacks, staff shortages, lack of time/resources etc.).

This history warns against what might become of madness, how it might turn to ashes and be forgotten. As I will elaborate further in the dissertation, psychiatric survivors/Mad Pride movements have sought to reclaim their voices on their terms and methods. “Survivor Research in Canada” (Landry) challenges what counts as evidence and how survivors/Mad people have been historically excluded from knowledge-production. Beyond metaphors, this emancipatory movement that gives madness an audible public-facing “voice” is not without its controversies and tensions, as madness is not a homogenous identity or political standpoint. As Landry states: “any analysis of survivor research or mad studies, I would argue, ought to take a critical perspective. It is only through a critical analysis that we can take survivor research concerns about the effects of discourse into account. For instance, how subjects are repositioned through a process of self-identification that talks back to psychiatry” (Landry 1441). What counts as survivor or Mad people’s knowledge is so difficult to define, because what “counts” cannot be

counted empirically, resisting mainstream categories and epistemologies. Again, to resist binary formations between madness/sanity, we must question how madness was invented in a search for sanity that was never found. Trying to shift the evidence “measuring stick” (Landry 1446) is incredibly frustrating when madness keeps trying to prove its value against psychiatry. Instead, we need to value mad epistemology on its own terms, in its own divergent and diverse discourse that does not resonate in even and harmonic tones. Social change requires a paradigm shift towards madness as a new kind music that requires us to listen otherwise: “In order to put an end to these recurring findings survivor research must use the knowledge it generates to make visible how conventional research practices discursively reproduce destructive experiences for survivors” (Landry 1446).

Psychiatric survivors have mobilized their lived experience to be recognized, to be treated with dignity and for their basic needs to be met. In 1980, at one of the first ex-patient/psychiatric survivor rallies in Toronto, Carla McKague spoke about the need for solidarity more than the need for psychiatric treatment. Based on her lived experience as an ECT survivor and her reflections on socioeconomic factors (lack of stable housing, a meaningful job) that led to her hospitalization, she elucidated how social-determinants of health impacted her life—long before public health institutions were on board with these ideas or even considered them relevant. The psychiatric survivor/Mad Pride movement was integral to ethical shifts within the mental health system, with many people contributing to this movement (artists, poets, policy-makers, teachers, etc.). Carla McKague’s call to action is one where health care professionals learn to empathize, as a starting point, towards deeper ethical commitments and responsibilities of transforming the values entrenched within these institutions (psychiatric education to practice). Carla was part of a larger movement, the Ontario Coalition to Stop Electroshock, that

held a public hearing in Toronto's city hall (Costa, *Mad Matters* 197) specifically about a female patient who was coerced into ECT treatment and when she continuously refused the psychiatrist tried to get her husband to consent. Their goal was to shift the values that trivialize lived experience, consider doctors as gods, and turn a blind eye to systemic forms of violence that perpetuate health inequities. But the work does not end with empathetic engagement, but rather, it begins with listening towards recognition and speaking truth to power:

One of the reasons that most of you are here is to ask what we as a community can do to help these people. What we need, first of all, is friendship, understanding, people who do not shy away from us because they don't quite understand us because we are a little bit different from the rest. We need a place to live. We need a job. We need legal protection. And mostly what we need is recognition that we are not some strange breed. (Costa, *Mad Matters* 197)

The psychiatric survivor and Mad Pride movement continue to mobilize the mental health system to listen to their concerns and critiques surrounding research, policy and treatment methods/praxis. The problem is that now, instead of being recognized, they are being co-opted and distorted in the patient engagement enterprise that espouses neoliberal values (Johannesen, Costa, Voronka). This kind of tokenistic listening is similar to the silencing mechanisms from the asylum era. Their critique is dismissed and discredited as legitimate epistemology.

Listening in Psychiatry

“There is nothing more healing than being found by another” (Mohl 12).

While Foucault critiques the impossibility for madness to say anything that can be genuinely received by biomedical psychiatry, the reparative *narrative turn* in contemporary psychiatry welcomes the messiness of patients’ voices and seeks to interpret meaning as co-creation, a work in progress. What is the context in which madness might speak and be heard? Can psychiatry as a paradigm listen to an experience as it is “lived” instead of how it is conceptualized by the medical model? Could psychiatry welcome the phenomenology of “hearing voices” alongside the checklist of schizophrenia symptoms? Can psychiatrists listen to their patients meaningfully if they are searching for symptoms within a personal narrative? Or do they listen more like a prosecutor looking for evidence to prove someone is guilty? Could they listen otherwise, from the place where madness speaks? Answering these questions would demonstrate how psychiatric listening is diametrically opposed to ethical forms of listening. Looking at psychiatric curriculum and education, I wonder if there is room for students to learn how to listen beyond the limits of diagnosis?

In “Listening to the Patient”, the first chapter of *Psychiatry* (2008), a textbook for medical doctors, psychiatry residents, and students, Paul C. Mohl attributes listening as the “key skill” (3) for psychiatrists to acquire to locate their patients. He posits listening as the “primary tool” (4) of psychiatry—and thus it should be the first learning-module that students encounter when they specialize in psychiatry. Like other psychiatry textbooks, the language in *Psychiatry* vacillates between “patient-centered” and “disorder-based” (McIntyre 887). Although there may be debates over how listening should be applied as a tool, no psychiatrist would argue against listening: it is generally accepted as an important part of the therapeutic process. Listening is the

first thing that must happen within the clinical encounter. The patient speaks of what is bothering them and the psychiatrist listens to find symptoms beneath the narrative of suffering. However, how the psychiatrist listens is dependent on the school of thought they ascribe to (cognitive, behavioural, psychodynamic, psychoanalytic, existential, etc.), the context they work in (clinical, private practice), and their orientation towards the patient. Mohl attributes these different styles of listening to the “art” of psychiatry that “involves guiding the depressed to tell their story of loss in addition to having the ability to name, describe and quantify symptoms of depression” (3). In Mohl’s eyes, psychiatrists are artist-investigators of the psyche. With the rise of biochemical, neurological, and medical interventions, psychiatry is losing its art; it is forgetting how to listen to patients’ anguish beyond biomedical diagnosis.

Just because the art of diagnosis has gotten more sophisticated during the last few decades (Mohl, 2), this does not in turn mean that patients’ inner experience should be abandoned. Perhaps the reliance on *words* to do all the talking fails to communicate what we cannot articulate or hear. When the meaning of the word stands in for the ethical gesture of *saying*, we fill up silence with meaning that remains flat, absolute, and fixed. Words enable thick concepts to hold our thinking hostage. Acousmatic listening, or listening to sounds beyond language, moves away from origins, gesturing towards the other places that the sound takes us, towards the imaginary, unknown, and that which conjures awe. As it stands, medical listening aims to name and organize to cure. As Gaston Bachelard reminds us, “The eye cannot necessarily go beyond a description of the surface, sight says too many things at the same time. Being does not see itself. Perhaps it listens to itself” (72). Through the act of listening, the witness is more imaginative than accurate. By letting go of the need for accuracy, a space opens

up for re-thinking the past and recovering for the future. This is a space of potential, possibility, and healing for patients: a place where they can re-member their past alongside a trained listener.

Psychiatric listening, also known as “examination” or “therapeutic listening”, began with Freudian psychoanalysis (Mohl 3) and allowed the doctor to “see” or visualize patients’ distress and thus help them work-through pain or confusion through creative, free-associative narrative. In his essay “Construction in Analysis” (1937), Freud paints the psychiatrist (or analyst) as an investigator who searches for the patients’ repression through perfected listening skills that can decipher and construct meaning out of jarring and seemingly meaningless fragments of dreams/memories:

He (the patient) gives us fragments of these memories in his dreams invaluable in themselves but seriously distorted as a rule (...) It is out of such raw material—if we may so describe it—that we have to put together what we are in search of.

What we are in search of is a picture of the patient’s forgotten years. (378)

Listening is thus a tool to visualize suffering, much like brain-imaging locates a tumor or lesion. Contrary to the great divide between the art and science of mental health care, Freud’s observations portray psychoanalysis as closely related to psychiatry. Emmanuel E. Garcia compares the relation between the two disciplines “as gross anatomy to histology” (63). Garcia deepens his comparison, drawing similarities between psychoanalysis and the microscope: both are invented around the same time and understood to grant “access to an entirely new realm of observation” (63). This emphasis on the ocular coincides with psychiatry’s desire to “find” (or define) patients with a “medical gaze” (Foucault *Birth of the Clinic*), to see their illness at the microscopic, or unconscious, level. Listening is operationalized as an imaging tool, an x-ray of the patients’ psychological patterns to justify a treatment (whether biomedical or

psychotherapeutic). Ocular dominance also plays into Foucault's notion of institutional disciplinarity: being built into therapeutic listening, it seeks to inspect, observe, assess, and surveil. The psychiatrist comes to the patient, unknowingly, under a medical gaze, a product of neoliberal values with epistemological traces uprooted from the Enlightenment.

The paradoxical role of medicine consists above all in this neutralizing gaze from which we cannot disentangle the conditions of its history from the density of discourse. The clinical scene of medicine came to exist as part of a wider structure organizing knowledge. This perspective prioritizes the ocular over all other senses—and renders the gaze the highest form of interpretation—yet the patient is not in control of this interpretation. The gaze, to be clear, holds much more than visual representations (what can be seen), it also assumes the ideological structure with which one can see/speak of objects and come to “know” them. In *The Birth of the Clinic*, Foucault addresses the genealogical growth of implicit knowledge (the gaze) particular to a historical moment that does not know its history as shaping the epistemological essence of future generations of medical professionals. The “medical gaze” is a product of institutionalized knowledge about the body, stemming from early anatomical studies during the 17th-18th centuries. Here, biological reductionism is tied to categorical thought that can order the things found in the world. Therefore, the birth of the clinic, as Foucault sees it, comes with a whole ideological shift in medical understanding of disease and health, one influenced by Kantian practical reason in opposition to the unconscious, unknowing shadow of superstition or metaphysics. As Foucault says: “Disease exists in the essential space of categorical thought, since this space constitutes it as nature, and yet it always appears rather out of phase in relation to that space” (9). The doctor's gaze was believed to penetrate surface illusions, which modernity then captured in new illusions surrounding scientific discourse. A striking illusion is how the

medical gaze assumes certain purity: things are what they are, essentially, without history. Another illusion is that the gaze exists before intervention—seemingly stripped of all discursive traces. But yet, there is a history of ideas regarding this supposed “true discourse” (*The Birth of the Clinic* 23)—shaping the medical gaze within the space of the clinic. As Foucault mentions, these illusions were necessary for scientific authority: the clinic “gained recognition for its observations” (*The Birth of the Clinic* xi) but not necessarily for its objective truth. This gaze granted a certain privilege to medical professionals to “know” more than the average layperson, because they could “see” things in themselves, empirically. The patient is thus placed in parentheses, observed and spoken for by the medical gaze.

As Derek Hook explains in “Critical Psychology,” this kind of listening encourages a confessional mode of exposition, “like the doctor’s gaze that yields knowledge like prescriptions of intervention based on visual analysis” (20). Listening is generally understood as a passive form of communication, a way for psychiatrists or psychoanalysts to connect with their patients’ lived experiences, but as an instrument, it is more like a purposeful, goal-oriented mechanism actively working to see the patients’ brains.

Narrative is the “raw material” (Freud 378) of psychoanalysis and psychiatry, and the only way to work with it is to listen to patients. This “raw material” needs to be excavated, examined, and understood from a medical perspective to be listened to. The *narrative turn* in psychiatry, a reconnection with psychoanalytic “talk-based” approaches, relies on coherent narratives that align with a psychiatrist’s ability to “understand” what the patient is *really* saying—what is said beneath the surface of speech. Diagnosis doubles for understanding. In this case, Mohl states: “Patients are storytellers primarily about their important relationships, who have the hope of being heard and understood” (4). Symbolically, the metaphor of being

understood works twofold: it alludes that the patient is “lost” (misunderstood/alienated), and thus it characterizes the psychiatrist as “investigator”, asked to solve an unsolvable aspect of the human psyche: the unconscious. Mohl equates being “found” through listening as feeling validated, loved, and secure in the world (13). Being “understood” suggests being found (3), and feeling at home. Even though therapeutic listening, as a medical technique, predates brain scans and the biomedical turn in psychiatry by several decades, it still reflects a desire to identify and categorize (to locate illness). Perhaps the only difference between the two modalities is that therapeutic listening can “find the patient” with less “objectivity” (Mohl 3)).

To be “listened to” is an urgent ethical desire: to be recognized and legitimized by another (Levinas, Todd). New research regarding mirror neurons demonstrates the neurological benefits of listening, finding that being listened to can change one’s brain:

Now we know that just as there is a neurobiological basis for the power of listening to heal, to lift psychological burdens, to re-moralize, and to provide emotional regulation to patients who feel out of control in their rage, despair, terror, or other feelings. The art of getting the patient to describe and quantify their stories of suffering, with the hopes of changing their neurological pathways, requires four key skills and abilities: hearing, seeing, comparing, and intuiting.

(Mohl 4)

All of these skills help frame the patient's story for better and more accurate diagnosis. Thus, when Mohl says he thinks listening helps psychiatrists “find” their patient, he is really talking about finding the right diagnosis to define the patient and treat them accordingly.

For this reason, therapeutic listening is based on an “interview” model, whereby the psychiatrist elicits a narrative based on “leading” questions carefully designed to align the

patients' answers with diagnostic categories and identifiable illnesses. Listening, as a means of diagnosis, is instrumentalized, neutralized, and objectified. Yet the only way psychiatrists can elicit highly nuanced stories of distress is by cultivating an atmosphere of trust, which necessitates "listening beyond hearing" (Mohl 4). This demands empathy as much as it demands neutrality, which may foreclose ethical or sincere engagement with the patient's story in a dialogical dynamic. The psychiatrist is posturing superiority by glorifying their ability to "reach" their patients, to lower themselves to their level, and "listen." Despite the goals of "patient-centred" care, the psychiatrist still has a mission to alleviate symptoms, and thus needs to focus on the "disorder" within the patient's narrative. As McIntyre et al. state:

Numerous studies have demonstrated that often the patient's goals for treatment (e.g. safe housing) are not the same as the psychiatrist's (e.g. decrease in hallucination). This dichotomy can often be traced to the interview where the focus was not sufficiently person-centered but rather was exclusively or largely symptom-based. (889)

Therefore, even while patients are encouraged to express their suffering in their own words, their words are pillaged for evidence, and are always inherently framed within a health/illness dichotomy. In "Interviewing the Difficult Patient", McIntyre et al. outline strategies for engaging the patient who is "treatment resistant" and unable to "focus" on their recovery. The authors describe how patients may be swallowed by their delusions, amplifying the scariness or unworldliness of their illness. Their words cannot be trusted. Being labelled as the "difficult patients" suggests one is not able to listen to "doctors' orders" and submit to treatment. The "good patient" is one who listens, who does not ask too many questions, who does not talk back. Thus the language of "patient-centered" care does not guarantee ethical engagement; in fact, it

may even obscure systemic power dynamics and sanism¹¹ embedded within the encounter by indulging fantasies of the “good patient.” Another imbalance is that the patient gives “their story”, their “lived experience”, as currency to access care—while the psychiatrist reveals nothing of their intentions, motives, experience, etc. They are veiled by professionalism and maintain respectful distance. Their story of care is never elicited or made transparent.

Mohl outlines the “crucial attitudes that enable effective listening” that psychiatrists must adopt to conduct good clinical practice. Patients will open up to psychiatrists if they trust them and if they feel safe. In *Psychiatry Reconsidered*, Hugh Middleton writes that trust might be the most important aspect of the therapeutic relationship between psychiatrist and patient—yet he does not identify listening as one of the ways to establish trust. He never mentions how psychiatrists can work to establish trust. Trust is an abstract after-thought that Middleton structures his entire argument around—it is a vague ideal, unachievable at best, and presumed at worst.

Mohl is careful to balance the diagnostic approach with an empathetic desire to help the patient, since the two must coexist within the psychiatric interview. One labels and defines the process of therapeutic listening; it requires *sensitivity* to the storyteller, integrating a patient orientation with a disease focus. The listener’s intent is to discover what is wrong, to put a label on it. Simultaneously, the listener is on a journey to discover. However, the clinical encounter is plagued with “the lack of time” (especially in emergency rooms, as reduced staff equates to lack of time). As a result, “checklist listening” becomes a default solution to “the lack of time”. The

⁶ *Sanism* was coined by attorney Morton Birnbaum in the 1960s, when he was representing Edward Stephens, a patient with mental illness who claimed he was receiving inadequate treatment. Law professor and mental health advocate Michael L. Perlin has perpetuated the term in legal literature, writing extensively about it since the 1980s. American activist and educator in the psychiatric survivor movement Judi Chamberlin coined the term *mentalism* in her book *On Our Own: Patient Controlled Alternatives to the Mental Health System*, published in 1978. Neither *sanism* nor this definition of *mentalism* appears in the *Oxford English Dictionary (OED)*.

psychiatrist will listen to fill a checkbox of symptoms and measure what they hear using scales “for objectifying the severity of illness to treatment: the ear is tuned only to measurable and observable signs of response to therapy and biologic intervention” (Mohl 5). The patient can be lost in the psychiatrist’s attempt to find them.

Listening Otherwise

“Saying does not happen through the content of what speaks, but through the nearness and orientation we bring to the other” (Levinas 34).

The concept of listening otherwise stems from dialogic ethics (Levinas), by which ethics begins in dialogue and listening suspends our desire to know the Other. This form of listening respects the Other’s absolute otherness and alterity without trying to contain, define or circumscribe it to a fixed interpretation. In the framework of dialogic ethics of listening otherwise, listening is an epistemology comfortable with discomfort: it remains “open-ended”, unfinished, unsure of what it knows. This is an epistemology that undoes itself, urges us to let go of understanding, to empty our vocabulary of hierarchy, and to let silence (or madness) speak. Listening is a mode of relationality that creates the possibility of learning from the Other instead of imposing meaning onto them in a symbolically violent manner. The ethical possibility of listening respects the Other’s alterity and attends to it gently: ethics always involves an engagement with the other’s otherness, such that one’s view of the Other will inevitably be partial and incomplete, and in this sense, the Other will inevitably be radically and utterly unknown because otherness resides beyond one’s thought (49).

In *Totality and Infinity*, Levinas espouses the notion that the history of European philosophy represents a history of violence towards the Other insofar as the alterity was always

reduced to the same, in the sense of intending to subsume the other into the sphere of absolute knowledge. Respecting the Other's unknowable difference is at the heart of Levinas' ethics, and he proposes listening otherwise as the most viable way to attend to this difference. Even if we are empathetic and deeply moved by someone's speech, it does not mean we are listening fully to the difference that marks their experience as distinct from our own. We always want to understand, to swallow the Other in our words, our experiences, our memories—we make meaning in this exchange. We listen to relate the information back to ourselves. Often, we do not realize the distinct boundary between our subjectivities—how we cannot ever know the Other; no matter how hard or how much we listen. The point is to let go of understanding, to welcome all that cannot be known, to hold the richness of absence. Levinas notes how listening is threatening to the ego; it plunges the ego in uncertainty. Thus, ethics for Levinas requires a responsibility towards the Other that is asymmetrical subordination. Turning towards the Other is an act of renunciation where we give up our attachment to what is familiar and understood. Reading Levinas, Gemma Corradi Fiumara in *The Other Side of Language: A Philosophy of Listening* describes listening as a risky undertaking: “Any new attitude must take on the semblance of a loss of the previous mode of seeing things and evaluating them” (152). To listen, one must let go.

In this sense, listening becomes a gesture *towards*, a gesture that never arrives at finite meaning. Levinas described this radicality of the Other as “a horizon”: we can only perceive its distance and never reach it. Building upon dialogic ethics and Levinas's work, Lisbeth Lipari describes listening as a voice that is always speaking, even if we cannot hear it (46). How we listen says more than what we might think, and it should be the foundation of all communicative ethics, especially if one is trying to express distress. Lipari writes, “listening engagement with

otherness that is itself a voice of awareness of receiving and obedience, the voice is always speaking” (135). She affirms the role of vulnerability in supporting the awareness of the radical alterity of the Other. Listening otherwise refers to the acknowledgement and acceptance of vulnerability of both self and other. Not only are we called forward to attend to the suffering of others, but we must also attend to our own suffering. Vulnerability counters the medical authority and rational logic within diagnostic listening practices maintained by psychiatry. Vulnerability in psychiatry would require a renunciation of power and a dialogic process of intersubjectivity and inner listening.

Thus, listening otherwise creates space for what might seem inarticulable. Inhabiting a symbolic space through listening can heal distress that cannot speak, the wound of not being heard or being forgotten. In *Learning from the Other*, Sharon Todd argues for the importance of creating a context for listening, where attentiveness is a response to something more than speech. Listening thus becomes a place in process, where undisclosed secrets, thought dead and gone, are revealed in other ways, beyond words, re-symbolized and read anew. Even as language fails, listening salvages the communicative relationship. This openness and uncertainty is difficult work, not a protocol or instrument, but an art form that takes years of practice as well as failure. As Todd stresses, listening to “that which is not easy” (27) and which has the potential of disrupting a sense of self requires courage and the ability to risk everything that keeps us feeling certain and sure of what we know.

One of the greatest aspects of listening otherwise is its emphasis on compassion before understanding. Empathy and compassion often get tangled and used interchangeably. Empathy, as Todd has argued, is not always useful for ethics: it does not require responsibility and can easily fuel ego compulsions to “save” the Other without respecting their alterity. Compassion is

also vastly different from understanding: while many of us think that we must understand in order to feel compassion, the engagement with alterity instructs that we cannot understand if we cannot first let go of wanting to know the other in a categorical way. Understanding means to throw away your knowledge and know that you cannot put yourself in the place of the Other.

Attending to patients in this way allows the psychiatrist to hold space for what they cannot know, what cannot be articulated or understood in a biomedical sense. How can a physician who is trained to diagnose, to find a biological root of illness, be able to listen in a way that does not reduce the person to an illness or a checklist of symptoms? Listening otherwise seems incompatible with the goals of biomedical care, or even psychotherapy: however, I think that it provides a useful exercise for psychiatry to think through how it prepares residents to become qualified listeners to experience. According to Rimondi, the likelihood of being listened to by a psychiatrist is pretty slim: “The main focus of the training of psychiatrists is on diagnosis and treatment based on the traditional doctor-centered approach to the psychiatric interview” (161). Their study confirms that the “emotional intelligence” of psychiatry is essential for *proper* diagnosis and treatment. They claim that active-listening skills with “emotion focusing skills should be a major learning target in psychiatry” (162). Although their study remains directional, they do outline two solution-focused approaches to listening (active/passive). They discuss adopting a patient-centered approach to listening beyond the goal of diagnosis. This approach requires “psychiatrists to dedicate special attention to focused patient-centered interviewing in terms of active listening skills which are underused by psychiatry trainees” (168). They also observed that doctors’ communication styles are formed during their undergraduate training and prove resistant to change (162). A form of professional defensiveness is formed during their

education and contributes to a mainly doctor-centered approach. Medical education is changing and needs to center madness and listening otherwise.

Centering madness as speech worthy of attention and giving psychiatric survivors a platform to speak does not mean that anyone is listening, fighting for their rights to fair and ethical treatment. Framing survivor “stories” in “recovery narratives”, PR campaigns, and patient engagement enterprises may serve to assuage guilt for centuries of abuse and make those in decision-making/system-level positions comfortable with their gestures of inclusion. These voices are sprinkled into reports, copied and pasted, but they are not attended to, no one engages with the *affect* within the chosen quotes. Although “guilt”, as Sharon Todd suggests, may provide a starting-point for ethical engagement with difficult or traumatic knowledge (56), to be done effectively it requires taking responsibility and attending to one’s limitations and/or failings instead of trying to defend against them. Psychology and psychiatry as methodology have yet to absorb the critical dimensions of Foucault’s work: they have neither engaged madness as an idea (with a long political history), nor have they understood the political economy and vested interests in *not* listening to its speech.

CHAPTER 3: *Janet Frame's Life Writing and Faces in the Water*

(...) remembering every note, although her sense of time seemed to have suffered. Listening to her, one experiences a deep uneasiness as having avoided an urgent responsibility, like someone walking at night along the banks steam, catches a glimpse in the water of a white face or a moving limb and turns quickly away, refusing to help or to search for help. We all see the faces in the water. (...) We smother our memory of them, even our belief in their reality, and become calm people of the world; we can neither forget nor help them. Sometimes by trick of circumstance or dream or a hostile neighborhood of light we see our own face. (Frame 131)

Janet Frame wrote long before the language of human rights and advocacy for psychiatric survivors. Moved by the deep uneasiness of her experiences in the ward, her voice challenges much of the violent and unethical practices performed in the name of care within the psychiatric paradigm. She does so with great spirit and inventiveness, by listening to her own madness speak through sonic metaphor. The above passage signals how we might all on the surface empathize with those who are incarcerated in psychiatric wards, but we take little responsibility when it comes to enacting social change to strengthen the quality of their lives. We do little to listen meaningfully to their grievances. We all see the faces in the water but do nothing until we see our face reflected. This forecloses any ethical possibility to meaningfully listen to or attend to the Other with urgency, intention, or purpose. Frame is suggesting that the dominance of sight and

our desire to “see ourselves” in our surroundings diminishes our ability to listen otherwise and engage with difference.

In this chapter, I focus on Frame’s 1961 novel *Faces in the Water*, which re-members her twelve-year stay in the New Zealand asylums (1945-1957) where she received electroshock therapy against her consent, as forced treatment. I also explore the soundscapes of the asylum and think about listening as medical and moral surveillance. I begin with an exploration of the historical and political context surrounding Frame’s writing through her autobiographical trilogy *An Angel at my Table*, then I move on to a brief synopsis of the novel *Faces in the Water* towards a deeper textual analysis of the soundscapes in the text that embody listening otherwise and madness as a new kind of music. Music in asylums might have been used as therapy or medicine for inmates (MacKinnon 92), but what Frame describes in her novel is a subversive force of reclaiming one’s voice through music that bends the rules in light of surviving ECT’s memory erasure.

Frame's autobiography provides insight into her fascination with music and soundscapes, which extend beyond *Faces in the Water* and reverberate throughout her life writing. Song is her introduction to poetry, and symphonic/orchestral music is a transcendental mechanism for her to experience and understand her inner emotions in a new way (to flow with her inner life, instead of trying to control it with strictly goal-oriented voices). It is also a way for her to relax outside of the mundane anxieties of Teachers College, a place that did not feed her thirst for imagination and poetic conjecture. I will explore the complex relationship between Frame’s development of “voice” and agency, her misdiagnosis of schizophrenia and how her creative process of listening and writing leads towards the compassionate integration of madness. I call this process, in Frame’s case as in the women who survived ECT’s memory erasure and chose to represent it through fragmented autobiography, “re-membering erasure”. Erasure is thus subverted from

being a site of suffering and emptiness to being a site full of creative and radical potential for transformation. She speaks from erasure to transform the soundscape of the ward as one of hopeless punishment to one of meaningful resistance.

Frame's writing is political and her medium of disruption is sonic. Her voice is powerful because it exposes the everyday life of psychiatric inmates/survivors in a compassionate tone at a time when their experiences were largely silenced and under-represented. Dolly MacKinnon, an Australian historian and sound studies expert, has written about the acoustemology and soundscapes of asylums often omitted from mainstream literature and scholarly writing on madness (78). Uncannily, *Faces in the Water* was published the same year as Michel Foucault's concept of madness cannot speak at the beginning of deinstitutionalization and the psychiatric survivor movement, which in many ways embodies that ethos. What is fascinating about MacKinnon's archival research is that asylums were not silent at all, but rather, they were clamouring with distress that went unrecognized: "while asylums silenced the mad, asylums from their inception until the 1950s with the introduction of psychotropic drugs, were anything but silent spaces (79)". Sound was used to define and differentiate between those thought to be sane and those seen and heard as insane (MacKinnon 79). Although Frame did not publicly identify as a "psychiatric survivor" per se, she did view her writing as political. Her writing, and particularly its phenomenological descriptions of sound, transmits what the asylum felt like and sounded like from the inside, but it also resounds with psychiatric survivors' voices (her own and those around her) and their need to be heard compassionately and legitimately within society. *Faces in the Water* symbolizes psychiatric patients' lives under erasure, with their muted voices, distorted faces, and more profoundly, the social imperative to attend to their distress outside of medical violence. Set in 1945, the novel profiles electroshock as "the new and fashionable way

of quieting people” (8). Frame’s experience of mental health issues was at a time when there was no such thing as “recovery” or “wellness” for someone with a psychiatric label. As she puts it, there were “no voluntary admissions; we were all insane under the Mental Defectives Act, 1928” (36). As I discussed earlier, during the asylum era, people who were diagnosed with a psychiatric disorder (or in some cases, “defect”) were consequently stripped of their civic voice, freedoms and/or rights. They were not allowed to have their own bank accounts, have jobs or participate in society (Frame 36). Asylums, much like the psychiatric wards of today, functioned as prisons for the unwanted, the poor and *unproductive* members of society, who were seen as a diseased population beyond hope (MacKinnon 78). To relieve the burden they were to their families, state-run asylums were set up to be places of confinement, structure, and order, in which for them to spend the rest of their days, safely tucked away from view. The rationale was to lock the unwanted away to preserve moral hygiene. When Frame highlights the soundscapes of the ward in her writing she is amplifying the voices of patients who have been erased and silenced from public discourse. MacKinnon traces the archival soundscapes of asylums during the mid-20th century, but the archives are mainly focused on the staff and institutional records, not the patients: “Medical records comprise the voices of the asylum staff (...) the sonic flurries, fluidity, fury and volubility of the asylum soundscape when committed to paper are made at once both static and silent” (78). Frame’s writing amplifies the voices that had been muted behind asylum walls: as she reclaims erasure as a voice that challenges medical labels and authorities, it becomes clear that this is a voice that talks back to psychiatry in a way that points to how psychiatry *should* listen to patients. Beyond diagnosis, this form of listening holds space for the unknown murmurs of consciousness, memories, and the politics of madness.

Janet Frame's Life Writing, Autobiographical Fiction of ECT: How to Re-member the Self under Erasure.

Both Frame's life writing and creative process entail a profound inner listening, as if to excavate the core of selfhood and allow it to speak for itself, without the memory of others' voices to interrupt its flow. But at the same time, Frame's life writing is entrenched with ancestry and attempts to channel those voices through her own. Her process was to listen as if the sea had stopped. Frame, as she describes in her autobiography, *An Angel at my Table*, always struggled with feelings of being at home within herself and within the world (11). This kind of listening happens at a limit, when everything we take for granted, like the ebbing and flowing of the ocean and the earth's rotation around the sun, can no longer be counted on. We are asked to listen in a completely new way, in a way that cannot be grasped with our current ways of relating in the world.

For Frame, life writing was a form of anchoring the self, so that she could one day say: "that's me" with confidence and pride (*An Angel at my Table* 320). To locate oneself in space/time through writing does not guarantee a purely independent agency, a self-made selfhood owned and defined entirely by us alone, a self that does not depend on how others interpellate or interpret it. In fact, Frame discovered that the more she wrote, the more she had to risk relating to others. One of the major concerns and themes that Frame illustrates through her fictional and autobiographical work is the interplay between time and memory and one's ability to speak for oneself as one is able to listen to the dead.

Frame was keen on autobiographical fiction; her writing, although highly imaginative and abstract to many readers, is always rooted in her life. Some literary critics considered her writing "amateurish" and undignified, which was highly centered on British standards and markets. For

Frame, autobiographical life is inseparable from a fiction writer's process: "Reality is the ore of polished fiction" (*An Angel at my Table* 320). Autobiography is found-fiction for Frame: "I look at everything from the point of view of fiction and so it wasn't a chance to be writing an autobiography except that it was based on fact" (*An Angel at my Table* 320). As a result, Frame has often been misunderstood by literary critics of her generation, in the 1950, 1960s and today. Literary critics and psychiatrists alike have prodded and pathologized her writing to find signs of madness, or, more harshly, incurable mental disability (Oettli-van Delden). Frame was criticized for the "logic" or plausibility of her novel *Faces in the Water*: How could Istina Mavet, as protagonist, represent her testimony so eloquently and imaginatively if her brain had been damaged in the asylum? How could she write an autobiography (which is what she proclaims in Chapter 1) if she cannot remember her life? If autobiographical fiction seems to be a contradiction, then writing an autobiographical fictional text about one's experience of memory erasure is near impossible. This is the limit-case. In a sense, literary critics were asserting madness cannot speak by devaluing how Frame spoke and transformed her life through fiction.

What the critics overlook is that both Frame and her protagonist Istina are writing about the experience of madness in a society that punished difference. Like many literary critics of the time, authors who suffered from mental breakdowns and were institutionalized were forever marked with literary pathologies. They became "mad writers", and their texts were pillaged for proof of their insanity (Oettli-van Delden). They could never escape the stigma of being labelled psychotic, and their literary work would be assessed much like their minds were assessed by psychiatrists, on trial for symptoms. An extreme example of this phenomenon is found in *An Angel at my Table*. Frame recounts being saved from leucotomy after her novel *The Lagoon* won the Hubert Church Awards for best prose book. Prior to this event, she was encouraged to stop

writing and be *normal*: “Everyone felt that it was better for me to be ‘normal’; and not have fancy intellectual notions about being a writer, that it was better for me to be out of hospital working an ordinary occupation” (264). In the 1930s and 1940s, it was impossible for someone like Frame to exist without being considered “abnormal”: being poor and a woman was a major contradiction with being very well-educated, not to mention her aspirations of being an intellectual poet and novelist. The psychiatric label prevented her from being a writer in the eyes of the medical staff that monitored her every move. Even after she escaped the hospital due to winning the literary award and was given a place to live and to write with Frank Sargeson, routine visits to the Doctor dampened her literary triumph. She routinely had to prove her sanity and explain that she was not the protagonist in the novel. The psychiatric label “schizophrenic” followed her into literary reviews and in her everyday encounters with people, from Doctor visits to grocery stores. Frame had to demonstrate the absence of scars on her temples for the Doctor to believe that her novel was fiction. She found the whole process to be dehumanizing and invalidating of her talent:

Later, when the book was published, I was alarmed to find that it was believed to be autobiographical, with the characters actual members of my family, and myself the character Daphne upon whom the brain operation was performed. Confronted by a doctor who had read the book, I was obliged to demonstrate to him the absence of scars on my temples. Not every aspiring writer has such a terrifying but convincing method of displaying to other ‘proof’ that she has been writing fiction. Daphne resembled me in many ways except in her frailty and absorption in fantasy to the exclusion of ‘reality’: I have always been strong and practical, even commonplace in my everyday life. (300)

Frame is right: most writers do not have to prove their sanity after publishing a novel about a character who received psychiatric treatment. There was an assumption that because Frame had based the character on her experiences within the asylum, that the novel had to be “true”. This is the first mistake that readers/critics tend to make in assessing works of autobiographical fiction. The second is the assumption that just because a piece of fiction resembles someone's life, it therefore means it is someone's life. This misreading relates to an ongoing theme of not being believed, compounded by memory erasure, that Frame expresses in *Faces in the Water* and her memoir *An Angel at my Table*. Frame’s writing seeks to make visible what has been hidden from history, and in that process she is simultaneously discredited while being credited. These contradictions serve to further demonstrate the tensions of representation and voice under the spectre of madness cannot speak and psychiatric pathologies. Searching for proof of insanity in her novel is the sign that her words are not trusted to be intentional art, but merely confessional accidents.

Another example of this literary “proof” of psychiatric diagnosis is found in *Sounds from the Bell Jar: Ten Psychotic Authors*, a text co-authored by literary critics and psychiatrists, which declares: “Psychotics often describe themselves as being cut off from the rest of the world as though they were mere spectators of life” (Claridge et al. 200). They are referring to Sylvia Plath’s introverted identity as a writer—her breakdown and eventual suicide. Using a diagnostic approach, literary criticism becomes a way to legitimize Plath’s insanity, to justify or explain away her suicide, and the author’s pathologization stands as the central lens for interpreting her work. Reductively framing Plath as “psychotic” (Clayridge et al. 200) locks her into abnormality, also trapping her writing within psychiatric discourse. The psychiatric pigeonholing of her writing silences and settles interpretation instead of opening it toward listening to the effect

embedded in the text, namely anger and rage. The psychiatric gaze forgets the gendered socioeconomic context that Plath playfully critiques in *The Bell Jar*. The “psychotic author” (Clayridge et al. 27) stands in as a universal reading, undercutting articulations of anger that circulate within the novel. It compromises her literary agency and subjectivity, because “psychotics” cannot get angry. They are always/already operating under the spectre of unreason. Consequently, such labels “cut her off” from the literary canon and turn her into a strange, unruly object to be fetishized and ‘othered’ by psychiatric language. She becomes the ‘madwoman in the attic’ of literature.

The literary disciplining of madness, an attempt to simplify complex existential problems with psychological/psychiatric discourse, is rooted in an anxiety of knowledge that cannot be understood or easily contained within hegemonic knowledge-production. Authors like Frame and Plath were trying to confront the social scripts that devalued their voices and stand up to the implicit ways patriarchal psychiatry is sustained in never-ending and dangerously covert systems of knowledge-production. Although the madwoman metaphor does little to subvert dichotomous or essentialist thinking, and that utopian visions of madness can be insulting to people with lived experience, most of these representations fail to locate or define women’s anger beyond a romanticized madness. As Foucault emphasizes in the *Birth of the Clinic*, we need to explore how the modern subject has been shaped through the cultural authority of the psy-complex. Frame writes from her embodied experience within madness, and she writes using madness as a method to resist the hegemonic social categories that constrained her identity, punished her behaviour and pathologized her imagination.

Freeing Frame’s words from the literary criticism that silenced and pathologized their hopeful meaning requires re-reading with an eye to unpacking what is being said beneath the

metaphors that seem trapped in the asylum. Can we overcome the quarrel of authenticity?

Language is a site of political struggle. The “personal is political”¹² highlights how one’s lived experience of oppression is part of a larger political landscape governed through discursive practices. Being able to name one’s oppression is part of the fight for liberation, yet language is always/already an instrument of patriarchal, capitalist white supremacy which makes it difficult to speak out in any authentic way by default. Marginalized groups and populations utilized “lived experience” as a method for articulating their experience of structural violence and discrimination within the public/private sphere, and to gain authenticity. Many “consciousness raising” groups during the late 1960s-1970s would encourage people to express their lived experience of oppression in order to mobilize strategies of critique and social change. As bell hooks, a prominent feminist theorist/ educator, states: lived experience offers people who have been systemically silenced and opportunity to “talk back” and hopefully be heard. hooks situates the language of lived experience as a site of struggle—how naming one’s pain can help transform it, and how the Black feminist community needs to first become subjects and legitimize their subjectivity through language: “the act of becoming a subject is yet another way to speak the process of recovery” (32). Another example of this kind of strategy is echoed in the

⁷ The personal is political was first publically coined by feminist, Carol Hanisch, in 1969. It makes the connection between subjective experience of oppression and systems of power. Hanisch noted that “political” refers to any power relationships, not just those of government or elected officials. In 2006, Hanisch wrote about how the essay’s original form came out of her experience of working in male-dominated civil rights, anti-Vietnam War and left political groups. Lip service was given to women’s equality, but beyond narrow economic equality, other women’s issues were often dismissed. Hanisch was particularly concerned about the persistence of the idea that women’s situation was women’s own fault, and perhaps “all in their heads.”

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“personal is political”, coined by Carol Hanish and popularized by feminist poet, Audre Lorde. Lorde locates Queer Black women’s experience within the mainstream white-middle class feminist movement to redress inherent inequity and racism within these so-called “safe spaces” (Lorde 7). Merging the “personal” with the “political” bridges gaps between private/public strategies for empowerment—it makes political work relevant and meaningful in people’s everyday lives. Ultimately, it illuminates how one’s experience of violence is not an isolated matter—it exists within a larger hegemonic political structure: “when we convert our experience into a theory, we enlarge its scope and include the experience shared by others similarly placed” (Kapoor 81). Valuing autobiographical “lived experience” as an authentic expression of knowledge permits intersectional perspectives of oppression and community-building, thus furthering equitable approaches for social justice work. Overall, subjectivity within knowledge-production acknowledges how knowledge is never neutral, but is rather a complex web of power relations and vested systemic interests. Frame wrote about psychiatry using its language while at once inventing her own. Naming her pain happens in her transformation, exaggeration and manipulation of it through these fictional characters that were based on the people she knew from the asylum. She becomes a subject through this ventriloquist-like manner of speaking, at a slant, in the words of others.

Finding our voice in the voices of others is part of what makes the reader/writer relationship so powerful and transformative. Daphne Marlatt in “Self-Representation and Fictionalysis” talks about the production of selfhood through the “mythical mechanisms” (Marlatt 1) that produce human being always/already as abled bodied, wealthy, men—and so, women are by default “non-man” (and of course nothing exists for those who lives outside of gender categories): as such, Marlatt claims that we need to find a counter-discourse, and that

women must seek the lost and obscure texts of the lives of forgotten women, women whose utterances “would never be valued by literary standards” (Marlatt 1). She urges for women writers to reclaim their realities and truth because in many ways, especially through “mythical mechanisms” women’s lives have been so fictionalized. As such, Marlatt is not interested in inventing as much as she is in the details of her life. She finds the sublime in the everyday. Even though Marlatt’s essay was published long after Frame’s novels, it shares a similar sentiment of exposing the beauty of unlikely settings in our lives.

Autobiographical fiction writing serves as a sounding board for one’s past that will not pass. It can be thought of as an exercise in letting go and transforming or exorcising painful life events. “Sounding out” one’s life under memory erasure, re-membering experience between the valence of fiction and history becomes Frame’s act of resistance. In *Storying Sadness*, Suzanne England speaks to the re-membering effect of autobiographical fiction, writing, “It is in speaking the unspeakable anguish of depression that one begins to recompose the narrative, to trace the threads of the story from the past to the present and to find a way to make new sense out of old material. The imagery of everyday life provides the space for reflection and transcendence” (England et al. 93). Similarly, bell hooks in *Talking Back* talks about how telling her story was linked to wanting to “kill the self without having to die” (155). hooks does not want to forget the past, “but to break its hold” (155). This is the essence of re-membering as a responsibility towards the past that haunts us and that we must transform through creative practice. As Derrida says, “We must transform/transgress our social historical mourning—re-visit, re-member, re-conceptualize and represent knowledge from the past” (Derrida, *The Work of Mourning* 66). Autobiographical re-membering in Janet Frame’s life writing and fiction creates a space for healing a past that would not pass.

Frame's work straddles the autobiographical and the fictional in a way that allows madness to speak. She captures what being alive was like for someone whose experiential analysis was undervalued and whose voice was repressed. Fiction based on her life was the best mechanism for her to reimagine a world in which her life could have meaning. Frame reclaimed what had been stolen through her pathologization. Her experience was devalued to the point where she needed to fictionalize it to make it "real". As Marlatt describes:

I think most women's lives have been so fictionalized that to present life as a reality is a strange thing. It's as strange as fiction. It's as new as fiction. I'm not interested in inventing because what actually happened is so huge...what's the necessity of inventing? Whatever it is that writing gets at; it's precisely that remarkable quality of being alive at this point in time. I don't see anyway of honoring that quality except by writing directly about our own life. (Marlatt 192)

The risk of sharing her truth, even in fiction, was in not being believed. Even if the act of writing was an act of defiance and reclamation, Frame put herself at risk of being shamed and devalued.

Literary critics' pathologization of Frame's writing can be seen as a form of gaslighting because they invalidate her experience of suffering as "attention-seeking" (Oettli van-Delden 34). The literary backlash against Frame's life writing, attempting to unearth inaccuracies and flaws in her moral character, are precisely the reasons why Frame stayed away from writing about her experiences as autobiography. She kept her life in the realm of fiction, because, as she puts it, the truth was far too unbelievable for readers to handle; it had to be softened through the craft of fiction. Thus, autobiographical fiction recovers narratives that are too painful to be told straight from memory without mediation, without being integrated into a mixture with imagination.

Frame does not symbolize madness per se; she symbolizes what it felt like to be unwell and what it felt like to be confused by those feelings. Her lush and somewhat psychedelic imagery resists the generalizations of psychiatry that name depression as a series of clinical symptoms. Her descriptions of the experience of “feeling bad” are relatable on a basic human level: it is hard to be alive in a world that thrives on exploitation. It is hard to be alive in a world where productivity is synonymous with meaningless repetitive labour, where sanity and wellbeing are incoherent concepts, and where people are expected to be happy at the expense of knowing how to handle sadness or distress.

Frame’s project seeks to frame madness as a source of subversive brilliance, so bright with darkness it casts an illuminating shadow. After her release from Seacliff, Frame was urged by her psychiatrist to write about her experiences in the asylum, the lost years. He suggested writing as a recovery exercise because she could not live without writing; it was her lifeblood and the only way she could situate herself in the world.

Despite the limits of autobiography as verifiable evidence of the “real” or the pure fictiveness of “fiction”, Frame’s writing has been reduced to genres and interpretative frameworks that do not honour its inventive liminality, hybridity, cultural significance and ethical gestures for reshaping how mad people are understood by society. Literary critics have diagnosed Frame through their textual analysis instead of welcoming her voice, instead of listening to the sonic textures and the weighted silences she conjures in vivid environments where poetic language inhabits prose, as a madness that speaks. Her fiction has been taken for autobiography and her autobiography taken for fiction, which is not too surprising, given the fluidity of the two genres. The confusion also points to questions of what constitutes “autobiography” because the autobiographical can be found in any genre. What made critics so

anxious over hybrid or experimental forms of writing at the time of Frame's writing career? The critics who gave her bad reviews for not adhering to the codes of genre, diminishing her craft, were calling upon her lived experience within mental institutions and with ECT to devalue the truth-effect or believability of her prose. For these critics, such as Williams, her use of the subjective voice is labelled "lazy" fiction, and she is disregarded as a bildungsroman narcissist (Williams 1990), someone who cannot make believe and deliver artful falsehood through pure imagination.

Until "memoir/life writing" and "creative-non-fiction" became genres that one could study in creative writing programs, autobiography was seen by many fiction writers as a means of bypassing the need for imagination (Hemley 3). Real life was to be kept away from fiction, as Leigh Gilore explains: "Autobiography's impediments to such working through consist of its almost legalistic definition of truth-telling, its anxiety about invention, and its preference for the literal and verifiable, even in the presence of some ambivalence about those criteria" (*Autobiographics* 129). At the heart of misattributions of Frame's writing, beyond the quarrel for aesthetic authenticity and purity, is the search for the meaning of her madness, the root cause and proof that it is real and exists. Her life of poverty, humiliation, grief and trauma not only informed her creative process, but enabled her to seek refuge in imaginative worlds that she rendered beautifully through malleable narrative structures. Literary critics would use words like "schizophrenic" or "OCD" to describe her writing in their close readings, and then legitimize the use of such language by tying it to her lived experience of being institutionalized as a mental patient, conflating her literary devices and innovations as symptoms of mental illness. Like many fiction writers, Frame weaves experiences that belong to her and others into a complex environment of imagination and memory to create a world that her readers can inhabit.

To say that *Faces in the Water*, or any of Frame's novels, are autobiographical would not be completely true, but neither could one claim them to be pure fiction. There is no such thing as pure fiction; there are always moments of one's life and memory that serve as clay to be molded for a new meaning.

Janet Frame's Life: An Angel at my Table

It is impossible to understand Janet Frame without understanding her socioeconomic context. She was born in 1924 to a poor family in New Zealand. They lived in several small towns in the south of South Island before settling permanently in Oamaru in 1930. Constantly moving, never dwelling in one location for longer than a year, gave Frame the feeling of being a "migratory bird" (*Towards Another Summer* 6), existing in many places at once without ever feeling at-home (*An Angel at my Table* 233). "Home" is a central metaphor in a lot of Frame's writing. Not having a secure and stable home led to Frame's feelings of insecurity and constant worry about the future. Her Oamaru world resonated with the widespread Puritanism that was typical of New Zealand in the 1930s (Tinkler 90).

Frame recounts the humiliation of being poor, the hunger and decaying teeth as a way to share her story, from her own perspective, outside of her psychiatric history. She writes of feeling like a social outcast, afraid of interactions with others and especially authority figures. She also talks of her refuge inside books and the world of her imagination. Yet, the shame of poverty is something she never put to rest and arguably was a contributing factor to her twelve years of moving in and out of mental institutions. Frame was not able to cope with the stress of daily life, getting a job and taking care of herself.

Frame's personality and interests did not fit into her socioeconomic class and the limited life prospects it offered. She wanted a life of knowledge and art, which felt like something she did not deserve, and it proved to be a struggle for her to eventually stand tall as an artist who solely lives off their craft. *Angel at my Table* can be considered a defense of her imaginative process, interwoven with the life experiences that grounded much of her fictional work. Long before there was language to describe the social determinants of health¹³, or the systemic circumstances that profoundly affect one's wellbeing, Janet Frame's shy and nervous behavior was diagnosed as schizophrenia. This misdiagnosis was repealed twelve years after she had been subjected to over 200 electroshock treatments without consent. Today she would be considered a textbook example of how poverty and early-childhood trauma can negatively impact the development of an integrated selfhood. At the pinnacle of her distress in the 1940s, there were no conceptual frameworks to understand how her distress was more complex than brain chemistry, but rather was interwoven with events far beyond biology or behaviour. According to Diderchesen's model of health inequity, "social position" is found to be the central mechanism in determining one's health and wellbeing, and this position is mainly composed of "social contexts", "social stratification" and "differential consequences" (WHO 5). These structural dynamics assign individuals to different class positions within society, and whether they have mobility to rise above their current position will greatly depend on State intervention (subsidies to education, housing etc.). Blaming the individual for their low social position and poor health is

⁸ The social determinants of health (SDH) are the social and economic factors that influence people's health. These are apparent in the living and working conditions that people experience every day. The SDH influence health in many positive and negative ways. Extreme differences in income and wealth, for example, have negative health consequences for those who are living in poverty and these effects are magnified when these people are congregated in poor regions. In contrast, those who are well-off and living in well-off regions have better overall health.

a neoliberal trope; it engages the magical thinking of *pulling oneself up by the bootstraps* and forgets how context often is out of one's control or *choice*.

Poverty and the tragic drownings of her sisters, Myrtle and Isabel, had a devastating and traumatic impact on her early life. Frame and her entire family were ostracized politically and economically; they were judged as being a “bad family” after the drownings of her sisters. Frame's cosmology as an “inward sun” appeared rooted in worlds other than her peers', as she was introspective and illuminated despite being clad in ill-fitting clothes and being ridiculed for having wild orange hair (*An Angel at my Table* 73). The prospects of fitting in were scarce for the Frames, even if the social and cultural pressures to do so were high. Frame had a “secret desire to be a poet” (*An Angel at my Table* 214) despite being poor and discouraged from the luxury of daydreaming (107), confined to being “a good girl, who was no trouble at all” (107). She started to publish in small journals during her adolescence which bolstered her confidence (*An Angel at my Table* 214).

Frame's mother's poetic sensibilities were a saving grace. Despite not being well-equipped to deal with the labour of everyday life, her mother did instill a sense of poetic imagination in her children, and she was an important influence for Frame's future as a writer/poet. Her mother taught her to look at the ordinary world with transcendental wonder, to see the sublime in the everyday, and would often show her how poetry was everywhere. Poetry was the link between the world of the living and the world of myth and spirit; it could help conjure relics of the past in the present as a form of hauntology. Much like the ancient poets who acted as society's oral archive of history, Frame's mother provided genealogies that transcended the divides of fact/fiction. She conjured the family's mythical origins through her engagement with the everyday world in a past-present tense. She spoke of “the ancestors” with the same

amount of mythology and processes that have much less to do with linear time than with the mysterious linkages of the hauntological. As Frame recounts:

The Ancestors—who were they, the myth and the reality. The Frames had a passion for making things. (...) Mother appeared to be rarely in the present-tense, or like an unreal person with her real self, washed away. Perhaps we were jealous of the space that another world and another time occupied in our mother's life; and although, perhaps fearing immersion in this foreign world, we struggled to escape, we were haunted by her tales of the Guards, the Herberleys, Diffenbach, shipwrecks in the Sounds, life in Waikawa Road and down the Maori pa, family life at the Godfreys, remembered as paradisal. (5)

Frame's mother showed her how to occupy more than one embodiment of time/space at once, to vacillate in realms of past-present reverie toward imaginative futures. Frame's passion for making things came from her mother. This is a skill that Frame honed in her writing, with her narratives skipping through time/space as a form of poetic re-membering. The point of this form of re-membering is not a search for accuracy, but a sense of meaning and connectedness to the invisible bonds of ancestry and the work of others that has led to where one is currently situated.

It is important to consider the contrast between the luxury of her mother's ability to live in dreams and memory with Frame's "poverty of memory" and its erasure. In *An Angel at my Table*, after winning the Hubert Church Award and being released from Seacliff, Frame describes her memory as being "shredded", "weakened" and "permanently destroyed" (266). These words followed Frame throughout her writing career; she continued to feel as if she had not deserved to be a writer due to her stay in the asylum and its impact on her brain. Unlike her mother, Frame was labelled and punished by psychiatry and society for trying to leave her lot in

life, for trying to escape the home. Although her writing “saved” her life (*An Angel at my Table* 264), it was difficult to fully recover from the intergenerational trauma that seemed to be saturated in her voice, as well as the psychiatric legacy that her writing was immersed in.

Charles E. Scott explains in the *Time of Memory* how “the poets relate the past and its figures, but in this seemingly pragmatic activity, they establish both a definitive past and a meaningful present in which the deathless live. They tell people who they are and where they came from by reference to bygone days and to an eternal present that is not linear in its disclosure” (121). Frame’s mother was able to see things that no one else could see; she could see the past in a remarkable ageless present. Never for a moment does the journey back through time make us leave our contemporary realities:

When Mother talked of the present, however, bringing her sense of wondrous contemplation to the ordinary world we knew, we listened, feeling the mystery and magic. She had only to say of any commonplace object, ‘Look kiddies, a stone’ to fill that stone with a wonder as if it were a holy object. She was able to imbue every insect, blade of grass, flower, the dangers and grandeurs of weather and the seasons, with a memorable importance along with a kind of uncertainty and humility that led us to ponder and try to discover the heart of everything (Frame 5).

In *An Angel at my Table* Frame sketches her artistic development against all odds. Frame’s attempt to symbolize *events homeless in time* is an act of reclamation, of taking back the time that was taken from her within the asylum. Her lived experience is tied to the act of remembering and meaning-making that restores the stories we can live with and that help us salvage a “sense” of coherence in an alienating social world of eternal recurrence. Survival

stories that live in the blurred edges, losing the cognitive tools to make meaning out of one's life. Growing up in poverty instilled in Frame a sense of lack and impossibility, a hunger to be like everyone else—to be a child with pretty things. For Frame, those pretty things were “impossible presents” (74) in her world of practical survival. The following passage expresses how lonely poverty could be, how it weighed down her spirit like the heavy lace-up leather shoes on her feet:

I felt desolate at school. I longed for impossible presents, a doll's house, a sleeping doll, birthday parties, pretty dresses, button-up shoes, patent leather, instead of the lace-up leather shoes with their heavy soles and toe plates, hair that fell over my face so I could brush it away saying “My hair is getting in my eyes...” instead of frizzy red hair ‘up like a bush’ with everyone remarking on it.

(74)

Frame's desolation was alleviated by the success of her poetry. Her first poem, written at the age of ten, was greatly appreciated by her teacher Gussy, who believed every child had a talent to be nourished through education (74). When Frame shared the good news with her family, they were proud of her, and her father supplied her with notebooks from his railroad job to allow her to write more poems. This early encouragement gave Frame a sense of belonging, a sense of her unique purpose. The prospect of having fresh notebooks to write in made Frame “dizzy with delight” (75). She describes this period of her life as being in a constant state of hunger for words (75). After seeing a musical film, for example, Frame wanted to know the exact words in each song. To appease this hunger, her older sister brought home song books so that they could see the words and follow along. Frame's early life was filled with music and words, which might have influenced the musicality of her later prose and the development of her theory of listening.

The Song of an “inward sun”

Folk songs were Frame’s introduction to poetry. She writes fondly of the impact of music on her psyche as an artist, how during her darkest times classical music made her understand the experience of recognition, of feeling understood and being at home in the world. In her autobiography, Frame describes herself as an “inward sun” (*An Angel at my Table* 55), shy and painfully introverted, yet vibrantly conscious and alive. Attempting to balance this internal dynamic was difficult; not until she developed an identity as a writer did she learn how to “stand on the rock of herself” (Frame 769) and to trust the worth of her unique imaginative voice, to speak on her own terms. Discovering the autobiographical roots of Frame’s affinity to song, music and sound (which are abundantly reflected throughout *Faces in the Water*) elucidates why marrying the two art forms made sense to her as an artist. Listening to a symphony was akin to reading a novel for Frame: “Why had I not known before that listening to a symphony was like reading a book in all its progressions with its special shape and silent and noisy moment?” (218).

Sections of *Faces in the Water* flow from structured symphonies to found soundscapes, as the narrative bends time and space into dichotomous rhythms. She writes about memory between the “ticking clock” and “rushing sea”—events measured numerically or experienced phenomenologically through sound. Frame has a concept of the asylum as an “orchestration of madness” where patients enact a “new kind of music” that is rarely listened to with compassion and attentiveness. This new kind of music is a “curse or cry”. The asylum, often composed as a monument of silence, is where patients are orchestrated, surveilled and silenced in a disciplinary fashion. However, Frame’s attention to this “new kind of music” is what elevates the voices we rarely hear, rising out of impoverished silence to a level of auditory power, amplified through her

sound metaphors and imagery. Her “inward sun” sings for those who have no means of being heard.

Asylum soundscapes were complex and they paradoxically amplified and silenced inmates voices; as MacKinnon describes, the architectural acoustics of asylums were made up of “hard surfaces, plastered walls, stone and brickworks combined with wooden floors thereby creating acoustically resonant spaces generated by unsound minds” (81). While inmates were silenced through diagnosis, forced treatment and restraints, their voices were amplified in the echo of the hallways and recreational spaces. Frame spent a lot of time describing the asylum acoustics that surrounded her in contrast to the natural landscape or the gardens around the built structure.

Prior to this shift in Frame’s life as a reader, living a life of writing was something that Frame always wanted but never thought she could practically afford, given her impoverished upbringing. She had witnessed her mother’s downfall and how her artistic dreams were extinguished by poverty. Frame knew that her family was not financially prepared to invest in dreams. The heartbreaking story of Frame’s mother, a brilliant singer and poet whose talent never saw the light of day (*An Angel at my Table*, 88), made Frame conservative in her ambitions: she settled on becoming a teacher because it seemed safe and stable, yet she clung to dreams of being a full-time poet. In her autobiography, Frame describes her writing style as practical and lyrical because she sought approval from her parents. Yet she also describes the influence of song and singing, an interest inherited from her mother, on her development as a poet. In a house that could not afford books, song lyrics were her introduction to poetry:

My poems were a mixture of conventional ideas about poetic vocabulary and the cowboy and prison songs recorded in my other notebooks and the contents of the

small popular song books brought home by Myrtle and the songs sung by my parents and grandparents. I continued to write my poems, sensing the approval of my parents—of Mother who saw the birth of something she had mourned as lost from her life, whose overwhelming might-have been was the publication of a book. She once sent a collection of her poems to Stockwells, England, which advertised regularly in New Zealand newspapers and magazines, and her joy at having the poems accepted for publication was lessened only by the knowledge that she couldn't afford the sum of money they quoted for publication, and although she resigned herself to never having the money, she could proudly say now and again, I've had a book of poems accepted for publication by Stockwells, England. (*Angel at my Table* 88)

This passage highlights not only the lack of New Zealand-based publishers who could support local writers, it also illustrates the dependence on the British canon and the difficulty of impoverished artists to be recognized. In the late 1930s, there were no supports for the poor to thrive as human beings, to say nothing of thriving as artists. Her mother's defeat and pride, "resigned to never having the money" but holding on to being accepted for publication by a British publisher was the highest form of achievement possible for someone of her socioeconomic status. Frame wanted to be published and to be recognized as a writer on the world stage more than anything in the world.

The notebooks given to her by her father became a place for Frame to express her "inward sun"—it was also where she would write about folk songs and poems that inspired or haunted her imagination. For instance, she writes about the impact of "Tender Wood Dove Softly Cooing in Your Nest," as reminding her of her mother listening to the birds while she managed

the household, their cooing sounds providing her with comfort. Frame also found comfort and respite in nature's rhythms; her novels and poems are rich with landscape and natural imagery. The tender dove song touched Frame deeply, and it was one of her obsessions as an early writer:

In the elm tree gently swaying, take your rest
I long to watch your gentle flight
Your spreading wings snowy white
All day at work I hear you
Tender dove
Take my little song to cheer you
With my love. (*An Angel at my Table* 71-72)

The song haunted Frame because she felt herself being like her mother, lonely, singing to the wood dove, her voice trapped within the walls of the household.

Frame writes about the impact of symphonies on her wellbeing. Being shy was not welcomed in Teacher's College; Frame felt constant pressure to perform, and she feared "being inspected" (*An Angel at my Table* 216). This fear of surveillance is sonically conjured by the authoritarian sounds of the headmaster's footsteps in the corridor: "I heard the steps of authority approaching along the corridor, so that a visit by the headmaster to a class sitting rapt with attention..." (216). One day, she decided to escape by attending a recital that made her feel at home:

I was standing outside the door of the gramophone room, trying to pluck up the courage to go in, I heard the piano being played (...) I still had little knowledge of classical music, and I had never listened to a long piece of music—a symphony or concerto, That day, Mr Forrest played a record of Tchaikovsky's Symphony

Pathétique, and among the handful of students I listened to the unaccustomed sounds dragging, dragging their awful burden and gloom, on and on, and when the music arrive at the ‘tune’ I knew...I experienced the delight of recognition.

(Angel at my Table 218)

The “delight of recognition” was tremendously important for Frame. During her career in Teacher’s College, she worked as a housekeeper to afford a room and board, constantly feeling like an outcast compared to the wealthier girls who could spend their free time studying or socializing. College seemed like a natural habitat for Frame; she could hide out in books all day and be rewarded for her intelligence. She adored teaching poetry to children and revealed their unusual use of language. But college is also where she had her first breakdown. Scholastic pressure fortified her perfectionism; her fear of authority, of being tested and examined, gave her tremendous anxiety to the point of not being able to function in everyday life. After her first breakdown and return home from the hospital, part of her process of finding herself was to buy an exercise book and to start writing her first novel *Owls Do Cry*. Of this period, she writes, “I gained my life as I had wanted it to be” (8).

Faces in the Water Synopsis

Faces in the Water (1961) is written in the first person, as a poetic testimony of Istina Mavet’s life in New Zealand’s psychiatric asylums and her experience of electroshock therapy during the 1940s. The novel begins with Istina Mavet describing an apocalyptic fantasy using soundscape. She listens to the city as an outsider, alienated and afraid. Istina imagines how social norms would dissolve into “hysteria” under the stress of a doomsday natural disaster. Citizens would become disoriented and confused—resembling Istina’s panic and uncertainty within the

mundane everyday of city life: “The streets throng, resounding with people who panic, covering the scissors, sucking the poison from a wound they can’t find (...) But the shop windows were speaking to me (...) I was not yet civilized, I traded my safety for the glass beads” (5). Although Frame is not overtly describing the chaotic sounds of the city, she infers a soundscape of anxiety and hallucination, one that questions the borders of real/imaginary sounds. This scene foreshadows her later diagnosis of schizophrenia, which by the end of the novel, turns out to be false: this misdiagnosis reflects a mishearing. As the social world and the institutional world of the asylum do not hear Istina as a subject or agent, they instead hear symptoms of schizophrenia. They hear a psychiatric label, when they should be hearing and attending to her suffering. Frame’s soundscapes allude to the regulatory function of psychiatric language and listening. Furthermore, she plays with the notion of “hearing voices” to question its intrinsic abnormality and subvert its claim of insanity. Instead of suppressing the hallucinated voices, they are listened to and allowed to speak as they need to. This freedom is contrasted with the medical model’s version of listening, in which the patient speaks and the doctor hears biological symptoms intertwined with a story. They hear the Diagnostic Statistical Manual (DSM), the categories of illness embedded in the patient’s speech: but they do not hear the patient.

Stylistically embodying Istina’s disorientation and existential homelessness, the novel disrupts the notion of linear time and storyline. She belongs nowhere. Not in the asylum, not in society or at home. Just as emotions exist outside of time, as Freud’s essay “Repeating, Remembering and Working-Through” suggests, Istina is perpetually confused about date, time and season as she struggles to figure out where she belongs. She is most at home in nature, most at peace amongst trees, rivers and flowers. The asylum is a dark and never ending winter, a direct contrast to the beauty of the spring and summer landscape in which Istina can simply be herself.

The river is an important metaphor for Frame, and it features widely in the novel as a both a source of freedom and sublime natural power. Frame underscores the centrality of the river as a symbol in her autobiographical writing. She writes about changing her last name to Clutha, after the Clutha River, to preserve her reclusivity: “I felt the river was an ally, that it would speak to me” (*An Angel at my Table* 195). The river that claimed both her sisters, face to face with Clutha, a being that persisted through all the pressure of rock, stone, earth and sun: living as an element of freedom, not in isolation, but “linked to heaven and light by the slender rainbow that shimmered above its waters” (*Angel at my Table* 203). Across Frame’s body of work, rivers are closely tied to Frame’s struggle with identity and sense of belonging.

One of the novel’s most compelling characters is Brenda, a leucotomy patient who was once a brilliant piano player, but post-surgery is unable to play simple songs on the ward piano. Sitting in the day-room with Istina, Brenda sees her face in the piano and feels like she should play. While she tries to play “Always Chasing Rainbows,” her sense of timing is off due to the effects of the surgery and she gives up in anger. Brenda’s frustration at her instrument results in her violently pounding on the keys in a fit of rage. This scene becomes the pinnacle of the novel. It is when Istina realizes just how cruel the entire institution is, and how Brenda’s rage is rendered meaningless by psychiatric treatments that destroy her cognitive abilities and communication skills. The nurses blame the piano for her agitation instead of the leucotomy. Brenda’s anger is pathologized, reduced to a mental disorder, and it is punished with restraints. Instead of interpreting her reaction as a genuine expression of loss from being wronged by a system that coerced her into giving up her most important asset, her anger is trivialized, and she is forbidden to ever play piano again by the nurses. In this moment of injustice, Istina contemplates the “faces in the water” (131)—the faces of people whose vulnerability make us so

uncomfortable that we must submerge them instead of attending to them. Istina sees this kind of forgetting as a social injustice and a way to avoid responsibility. At the core of this repression is the fear that one day we will see our own face in the water. Istina realizes that in an ethical system, Brenda would be encouraged to play piano. Her emotions would be engaged and listened to as valid expressions. Istina can no longer ignore the social complicity in Brenda's plight. The metaphor of "faces in the water" is compelling; it strongly evokes Emmanuel Levinas' ethical concept of the "face" (*Ethics and Infinity*) and Lisbeth Lispari's theory of listening otherwise. The singularity of the face directs our attention to the universal that we can never escape, as we are forever indebted and responsible before the infinity of the Other. This relationship to the face (the Other) connects us back to the whole, the unknowable infinite complexity of the universal that we must remain open to receiving through a "quiet listening, vigilant against its own interference, cautious of its own interference, careful not to disturb" (Levinas 45).

The level of anxiety and surveillance that Istina observes varies depending on which ward Istina is held in. Ward 2 is coined the "disturbed ward" where all the "trouble" patients are locked away, and Ward 7 is the privileged ward where patients are given luxuries such as penny candy and trips to the garden. There is also the TB ward, where patients wait to die. The further along Istina goes within the asylum, the more her memory disintegrates due to ECT, and the more fearful she becomes. She feels herself becoming more and more docile, but she is still filled with sadness and increasing anger at the injustices around her that she is powerless to address. Istina thinks that she is being cured of having an individuality, which being an artist from a poor family was a disorder in the society in which she was born. One of the ways she comforts herself from the constant terror is to escape into memories of poems and her mother's songs. Istina becomes fed up with the routine use of ECT as punishment, and one day, she escapes. She runs

out into a field and keeps running until she passes out. She is later found by Sister Bridge, one of the nurse-nuns, and is severely punished and put in seclusion. This stunt leads to Istina being convinced that she needs a leucotomy to let her “unsuitable personality fly out like a migratory bird” (213). However, she is soothed to find out that Dr. Portman, a recent graduate in the “new attitude” of Behavioral Psychology that understood mental illness as a kind of “childishness” that could be cured in a “Victorian environment with the persuasion of stern speech and edifying literature” (210) and he grants her parole.

The novel ends with the promise of Istina being granted parole and waiting to be sent home. There is a celebration called the Bowling Green, a sort of garden party on the asylum grounds. Istina is hopeful but anxious, fixated on the nurses’ words “you must forget this place” (223). The image of being received by “her people” (her family) with open arms, but their arms are made of spikes, proves to be unsettling. It leaves readers pondering whether Istina will ever be welcomed into the world and live as a free woman. We never find out if Istina makes it out alive. She ends her story with the nurses’ last words, repeating her need to forget the asylum if she is going to make it in the “real world”. Then Istina addresses the readers by saying, ironically: “And by what I have written in this document you will see, won’t you, that I have obeyed her?” (223). It ends as it begins, with readers left without direction as to “what happens” or “what happened”. This kind of narrative ambivalence suggests that “what happens” doesn’t matter; Istina is forever a prisoner of the asylum even if she physically leaves. Her mind is not the same, parts of herself have been permanently erased and she is forever scarred by the abuse. The only hope is that she survived to tell her story as coherently as she could and that it may inform institutional change.

What I find fascinating about being a reader, far into the future, is that institutional change *has* happened: The asylums have closed, and “mental health” is now understood from a recovery-based perspective. In spite of these changes, the treatment of psychiatric patients remains problematic. Biomedical psychiatry still has much to learn on *how to listen* with compassion, empathy and from a patient-centered perspective to narratives that might not *make sense*. They can learn this from Janet Frame’s representation of the impact of not being heard—and, most importantly, they can learn this from the patients they are meant to care for in the present-tense.

Faces in the Water: Literary soundscapes and theories of listening

Janet Frame wrote *Faces in the Water* (1961) as a therapeutic exercise while she received care in London, under the advice of the psychiatrist Dr. Crawley; she was listening to doctor’s orders. He believed that it would be cathartic and beneficial for Frame to work-through her asylum experiences using poetic fiction. At the heart of writing *Faces in the Water* is Frame’s hope to shed light on an obscured section of society, to destigmatize improve the lives of people behind the asylum walls: “If a few revelations would help get the hospitals improved and perhaps help change the public attitude to mental illness...Old buildings can be pulled down and new ones put up overnight but it is harder to deal with the invisible structures of suspicion and fear” (Tinkler 97). Frame believed poets and writers were the “moral legislators of the world” (Tinkler 100), whose job it was to expose the injustices veiled by social habit and convention. Regardless of the impact of her writing at the time of its publication, she understood that the societal perception of people living with mental health issues was going to be harder to change because those hardened ideas are adaptable to social progress. Stigma morphs with the times, and it can live covertly in new buildings, public health slogans and ad campaigns without anyone noticing. Although

Frame wanted to expose asylums for the horrors that they were, she was also apprehensive because the text was fiction based on the “most private” aspects of her life (Tinkler 97).

MacKinnon’s acoustic archival research of Australian and New Zealand asylum’s aligns with what Frame describes as the “Season of Peril”, how sound operated as a mechanism of discipline and regimented gendered musical therapy:

From the nineteenth century onwards in Britain, America, Canada, Europe, South Africa, India and Australasia, the treatment of the mentally ill saw an increasing move towards incarceration in purpose-built asylums, which not only comprised, articulated and gendered architectural spaces, but also implemented a regulated and regimented soundscape. Architecturally, asylums comprised hard surfaces, with plastered walls, stone and brickwork combined with stone or wooden floors, thereby creating acoustically resonant spaces that amplified the sounds generated by unsound minds. (78)

MacKinnon asks how sound was used to both punish in cure and how those sounds are difficult to trace historically without the accounts of patients themselves. This is why Frame’s novel provides experience evidence of the asylum’s soundscape, ECT treatment and its impact on memory.

Although Frame’s emphasis on sound in *Faces in the Water* (1961) is not pure phonography, it does embody a phenomenology of listening otherwise (Levinas, Lispari, Voegelin, Todd). *Faces in the Water* is a call to recognize ourselves in the Other, not to swallow their difference in our attempt to empathize or understand, but to reflect on their human features, the grain of their voice that resounds in our everyday engagement with the world. In a sense, Frame’s writing turns sound into a verb able to lift madness out of its communicative

imprisonment and into the realm of harmony, compassion and ethics. *Faces in the Water* poetically and sonically straddles polemics. ECT as “the new and fashionable way of quieting people” (8) as both miracle cure and as torturous punishment.

In this section I map the various soundscapes in the novel and analyze them according to the ethics of listening I outlined in Chapter 2. There are four major soundscapes: cityscape, asylum, nature and internal world/voice. Each represents a built or organic environment. She attentively describes the sounds of each environment to create a space for these women’s voices to speak beyond the limits of psychiatric institutional language.

Within these sonic metaphors, Frame draws attention to power and ethics in relation to listening and recognition for psychiatric inmates whose voices, memories and experiences are systemically erased. She writes sound as a call to action for us to listen to those who are trying to speak but are being drowned out by institutions. Then, I move into more micro stylistic analysis of her sonic metaphors and their symbolism.

Like all of Frame’s novels, themes of alienation, confinement and selfhood are found throughout the non-linear storyline. It is written in an experimental narrative form; Frame blends dreamscape with the mundane edges of realism. The main character, Istina Mavet, is a figure who arrives to the reader without context or background; we never find out how she ends up in psychiatric confinement. Yet the novel begins fully immersed in this character’s psychological landscape with intensity and disorientation. As readers, we are as lost as Istina. We soon discover that this is a story about Istina Mavet’s loss of selfhood, memory and sense of time after being subjected to 200 treatments of ECT that she never consented to. Later, we discover that this is also a story about the terrible conditions of asylums that psychiatric patients lived in until they were released decades later (or until they died). Istina’s story is a phenomenological and auto-

ethnographic record of lives under erasure, lives that were not meant to be recorded by history. As such, the novel stands as a critique and examination of society's treatment of distress and poverty. Istina honours each patient. Through her voice we see, hear, taste, smell and feel in the asylum from an intimate, emotional perspective. Istina is a character whose main role is to listen, to be a witness and to make-meaning out of the chaos.

Frame's novel makes the case for listening to memories under erasure as resistance through engagement with fragmented testimonies of electroshock that speak out-of-order, that have been displaced and replaced with the promise of erasure as miracle cure. Her thematic use of sound images, sonic metaphors, and soundscapes to illustrate the emotional extent of the shock experience provoke readers to "listen to" the disenfranchised, forgotten and silenced mad women in her novel. She also calls attention to the lack of humanistic care and listening within psychiatric procedures. Unlike most authors in the electroshock canon (Plath, Kesey, Fisher), Frame uses sound metaphors to situate the protagonist, ontologically and politically, within the anxious landscape of society and the asylum.

Salome Voegelin begins her book *Sonic Possibilities* with musings on "textual phonography," explaining that writing produces imagination for the reader that is not the sound heard "but the sound generated in her action of perception of reading about sound." (3) Writing is a form of sound recording that triggers our *imaginations* of sound, not the sound itself, but the idea of what sound could be: "I use words to grant you access to sound's present unfolding for you not to hear the same but to hear possibilities" (3). This method of treating sound as a verb that rewrites the experience of listening creates new possibilities of existence. As Voegelin elaborates, there is a dialogic reciprocity between the reader's internal voice and the text that transforms perception and understanding of 'the real': "the production in the reader's auditory

imagination of what it might have been that I heard and what they might have remembered to have heard, or might go on to hear as possibility of my words and her present auditory environment” (3).

The Season of Peril: Listening as a Safety Measure

In this section, I map the ways in which the asylum functions as a sonic panopticon to surveil inmates and I demonstrate the use of listening for patients as both a means to stay safe and to learn how to speak out for one’s human rights. Istina’s “Season of Peril” is a time of listening to the asylum, to survive its cruel rituals and prison-like environment. The sounds of ECT are represented as mechanisms of fear that serve primarily to control patients. This form of listening is hopeful, despite the terror she must endure. Frame’s use of literary soundscapes alludes to the regulatory function of psychiatric language and listening, and happens through Istina’s ethnographic descriptions of her surrounding soundscapes. Using sound as both a mechanism of fear and safety, Frame creates a phenomenon of “shock” that intersects with speech and the unsayable. In this upside-down world, monotony competes with timelessness; Frame contrasts the two extremes to highlight how the protagonist is caught in a never-ending cycle of hope/despair. Frame’s soundscapes of the asylum (sonic panopticon) offer insight into the lack of listening and human dignity for patients at the time and makes the case for ethical reform to psychiatric practice.

“The Season of Peril” is a refrain that Istina Mavet invokes throughout the novel—it refers to memory erasure caused by electroshock, a time of endless winter, a time where she is trapped in an apocalyptic nightmare where no living organism can survive. In this section, I map out sentence-level sonic imagery as entry points into larger themes on listening, discipline,

punishment and surveillance. The sonic acoustemology of life behind the walls of the asylum is something that is not recorded in most historical accounts. Since deinstitutionalization in the 1960s, many asylums have been turned into museums or memorial sites, but few of them have the soundscapes of their recent past. Frame's novel could be read as a soundscape recording of life on the inside, from a patients' perspective, one where madness sings its own songs and speaks its own verses liberated from the regime of linguistic medical dominance of pathology and control. As Dolly MacKinnon has stated, there is a lack of sonic interpretations of this psychiatric survivor history that regulated intersectional identities of class, gender, race religion within the asylum, and this history is one that is clamouring to be heard in the present:

Many facilities now stand deserted and abandoned, giving a false acoustic impression of madness as silent. From their inception and construction in the early nineteenth century until the introduction of drug therapies in the 1950s, asylums were sites of noise, which linked different types of sounds to specified architectural spaces. These now empty and quiet buildings belie their noisy and acoustemological past. (77)

The "Season of Peril" refers to the fear and distress felt by the asylum inmates and how listening could be used as a safety measure to weather the punitive ECT treatments. I also map out the parallels between this kind of anticipatory listening, sound surveillance and selfhood management in psychiatric wards. As medical anthropologist Tom Rice puts it: "the ward soundscape can play an important role in creating and confirming a particular experience of patienthood, bringing patients to experience themselves as patient-selves" (22). Institutional discipline was defined by the creation and instigation of silence and sound; for example, in Frame's novel the nurses use sound/silence to dictate behaviour. Similarly, MacKinnon talks

about the use of whistles to regulate unwanted behaviour and how "meals were to be eaten in silence only acceptable music was to be provided by staff" (82). The "Season of Peril" is where Istina (and by proxy Frame) realizes that she is a patient and no longer a free agent, no longer "self" but "other". In this section, I analyze how Frame's motif of distress is created through a sonic panopticon where nurses and doctors enact disciplinary forms of listening within an institutional rhythm of control and surveillance. This sonic panopticon sustains patienthood within a fear-based anticipatory listening, always on edge as they await punishment for "bad" behaviour.

With the recurring phrase "the Season of Peril," Frame symbolizes the long duration of depression and the hopelessness of being incarcerated in an asylum and being surveilled through sound. "The Season of Peril" also displaces the subject in time/space: they wake up in winter even in the middle of spring, and despite a bright sun outside, they are cold. The symbolic weight of winter gives Frame's account a hopeless tone. Life seems impossible in winter; nothing can grow or bloom. The cold is stagnant, absolute and violent. The only way out is to learn how to listen as a form of resistance, to stay safe by anticipating threat and to cunningly time one's actions accordingly. By knowing how to act within the "time of the asylum"—within this rigid and regimented world, much like prison, where bodies are regulated under an authority figure's watch—one can appear "sane" if their timing is right. Being able to harmoniously flow within the "time of the asylum" allows one to be set free, to be seen as "cured."

For in spite of the snapdragons and the dusty millers and the cherry blossoms, it was always winter (...) and it was always our Season of Peril: Electricity the peril the wind sings to in the wires on a grey day. Time after time I thought, what

safety measures must I apply to protect myself against electricity? And I listed the emergencies—lightening, riots, earthquakes, and the measures provided for the world by man’s Red Cross God Safety to whom we owe allegiance or die on the separated ice floe, in double loneliness. (Frame 11)

In the above passage, Frame creates a storm image that sings terror. The violently singing wind also mimics the harsh words from the nurses and the dangerous living conditions within the asylum, evoking the persistent emotional and physical abuse that Istina must withstand. The accompanying soundscapes that Frame uses to describe and enhance “the Season of Peril” are associated with the coldness of the institution, the surveillance and authority of medical staff. When Istina reflects that her stay in Seacliff was a “time of listening” (11), Frame is emphasizing how the protagonist can stay safe by listening to the rhythms of the asylum and its people. To survive within this stark landscape, Istina must learn to listen. Listening enables an intuitive defensive stance, to learn how to detect when danger is fast approaching:

It was a time of listening—to the other patients walking along the corridor for breakfast; the silence as Sister Honey, her head bowed, her eyes watchfully open, said grace: ‘For what you are about to receive the Lord makes you truly thankful. (11)

In this passage, we learn that listening is a way to predict what the nurses might do next, what painful treatment is about to be given. “It was a time of listening” (11) means that she spent most of her time in suspense, in anxiety, even if the nurses encouraged her to be “thankful” for the treatment she was about to receive. Istina is to receive shock with grace; as if it were a meal, she is meant to give thanks. The conflation of treatment and punishment is palpable throughout the novel. The voices of authority (nurses, doctors) interrupt and speak over Istina, and ultimately

this literary device is meant to confuse readers, to enact in writing the competing voices in one's head. To add to our confusion, the opening paragraph of the novel reads somewhat like an acid trip, a psychedelic opening of consciousness or a different way of perceiving the world. Istina is presented as having a highly symbolic and affective sensitivity to the world around her. The merging of safety, salvation and cure suggests the liminality between medicine and religion. In this merging, recovery is only possible in one's surrender to an authority figure—it cannot come from within or from spiritual self-empowerment. One must give up their subjectivity, admit their illness as sin and beg for forgiveness. The novel opens with an elusive statement about safety (gendered as male and poised as a spiritual God-like savior) by a paranoid protagonist:

They have said that we owe allegiance to Safety, that he is our Red Cross who will provide us with ointment and bandages for our wounds and removed the foreign ideas the glass beads of fantasy, the bent hairpins of unreason embedded in our minds. (3)

Safety as a concept denotes protection from vulnerability or risk—but it is one-sided given by the Red Cross, by the establishment of institutional law and order. It also denotes a fear of the unknown; staying safe means knowing what to expect and being prepared for the worst. Safety is not something one can create for oneself; it is ordained from above in a set of commands “lists of safety measures” (3). Frame begins the text with a visual saturation of anxiety, a highly imagistic representation of its internal and external manifestation. It is a landscape that later expands into auditory textures. But her opening statement also contains the voice of authority that vows to “protect” the vulnerable juxtaposed against the voice of collective fear (or the collective memory of fear). Frame's use of biblical connotations like “Red Cross God ” and references like environmental disasters, lightning storms, and the apocalyptic opening of the earth suggests how

safety is authoritative, puritan and tied to medical religious ritual. The speaker's voice, unknown to us at this point, imaginatively juxtaposes Christian iconographic imagery (Cross) with medical symbols. Frame holds the logic of salvation, both spiritual and physical, within this split image. The promise of modern medicine is not unlike the promise of eternal afterlife. By accepting its message, much like welcoming a faith in Christ, the speaker trusts in a divine economy that will return them to a state of sanity. The "ointment and bandages for our wounds" (3) contain medical and ritualistic meaning that assert to "remove the foreign ideas, the glass beads of fantasy, the bent hairpins of unreason embedded in our minds" (3). The concept of "the foreign" is linked to fantasy and unreason: a mythic "other" thick with difference and distance. What is foreign is to be feared and policed. What happens, then, when foreign becomes familiar?

Frame goes on to conjure an apocalyptic scene where anxiety is sonically palpable. Her "dangerous reality" (3) is one of disasters waiting to happen, being in perpetual states of emergency and collective preparation for the end of the world. The uncanny collective voice, "we" without concrete or direct reference to a specific group, could suggest the narrator's split identity. Perhaps they identify as a collective set of voices, or they simply identify as "we" and not as "I". Or it could symbolize the "we" of the asylum, the patients' collective voices that have been muted and silenced within the medical landscape of care. But with the "we" there is a "they." "They" is the voice of perceived authority, the voice of rules and regulation: the voice of law.

Moving away from the industrialization of the ear and the sonic panopticon of the asylum, Frame symbolizes the acousmatic "ecological voice" (Schaffer) of natural environments as liberatory and crucial for self-development. There is a stark division of perspective between the natural world and the built institutional world for Istina; this division is like a beam of light

refracting in a prism that causes colours to split into a spectrum. Istina's fascination with the natural world is a way to return to a state of wholeness, of pure being, without the words or labels of society and psychiatry. She listens to nature in order to give it a voice, and the earth speaks through her ear. Returning to a place before language, in the flow of instinct, she rediscovers joy amongst flowers, birds and sunshine. Music falls out of the earth's rocks and roots, its trees and rain. Istina could breathe onto the trees and make them speak. Nature soundscapes provide solace from the sonic panopticon. The birds, trees and wind help Istina reconnect with her past self; she is transported to a time when she was free. Sound theorist Pierre Schaffer describes environmental soundscapes as necessary for the development of voice, stating that "we could not express ourselves vocally without the wind we first inhale from the atmosphere and then exhale over the cords of the larynx perhaps we flatter ourselves when we think that our voices belongs to us alone" (Pettman qt Schaffer 70). Istina is sonically connected to her environment and suggests how voice is co-created with the world which troubles the dominance of human subjectivity over nature. Her solidarity with ecosystems is part of her learning to *listen otherwise* to the unknowable other with compassion, humility and curiosity.

However, the sensory deprivation of the asylum, the dark, cold and damp isolation, renders Istina emotionally volatile and unable to find the ground to recognize her voice. As such, the lines between her identity as a patient blurs with that of being a prisoner. Tom Rice in his sonic anthropological study of hospital soundscapes talks about how the machinery and the sounds they produce remind patients of their illness and inability to leave the hospital creating a subjectivity that was under "persistent medical scrutiny" (22). In *Faces in the Water*, Frame sonically juxtaposes a lightning storm and the sound of the ECT trolley suggest how patients/prisoners were perpetually on edge, never knowing when to expect a sudden shock as

punishment: “I continued to have ECT, dreading more and more the sound of the trolley and the stifled screams as it moved from room to room, nearer and nearer.” (67) Her dread and fear of the sound of the trolley highlight the importance of sound in creating the asylum landscape, it signals to the readers just how silenced and oppressed each inmate was at this time. The asylum sounds like a prison, which inhibits Istina’s ability to be in touch with herself and to listen to the voice in her head that was seeking comfort and protection from harm. There are also tones of ritual within the asylum, the scheduled treatments and daily routines are all timed with specific sounds (bells, alarms, nurse calls, trolleys, etc):

The soaked cotton wool being rubbed on our temples until the skin tears and stings and the dregs of spirits run down our ears making sudden blockage of sound, there is the final outbreak of screaming and panicking (...)

And now there is the sound of the early morning catarrhal, the springing squeak of rubber soled-shoes on the polished corridor outside, syncopated with the hasty ping pong steps of Cuban-heeled dusty shoes. (16)

In the following passages, Istina collapses the image of the patient/prisoner; while she awaits ECT treatment, she feels like a prisoner on death-row. This prisoner trope is also found in other ECT literature like Sylvia Plath’s *The Bell Jar*. Although the execution imagery is similar to *The Bell Jar*, in which the protagonist, Ester, fantasizes about the execution of the Rosenbergs’ in NYC which foreshadows her psychiatric hospitalization and ECT, Frame uses the image to signal the timelessness of laws that serve to end people’s time on earth. She is also commenting on the futility of ritualizing what is instrumental, what is unnecessarily done in the name of state law and serves no justice in the process. Istina is cut off from time itself, in a liminal space between the dead and the living. She is a person that no one will remember:

It is said that when a prisoner is condemned to die all clocks in the neighbourhood of the Death calls are stopped; as if the removal of the clocks will cut off the flow of time and maroon the prisoner on a coast of timelessness where the moments like breakers, rise and surge but never touch the shore. But no death of an oceanographer ever stopped the sea flowing; and a condition of sea is its meeting with the land. And in death cell time flows in as if the cuckoo grandfather clocks and alarm clocks were striking simultaneously in the ears of the prisoners. (24)

Time stops for the prisoner who is about to be executed: their names will not be remembered, they die stigmatized and anonymously as “a bad person”. Frame compares this death to the death of a valued member of society, “an oceanographer,” which is an apt metaphor. The oceanographer is a scientist of the sea, and although he has vast knowledge of the ocean, he cannot dominate or control it, and his death will not impact the ecological survival of the ocean. His power is limited compared to the power of earthly forces. Frame is suggesting that certain environmental conditions are inevitable, and that no amount of intervention can prevent them. But despite this contrast, the prisoner is a prisoner of time. The alarm clocks that ring in the prisoner’s ears signify artificial “human” time, the time of sentences that force time onto individual bodies. Time spent locked away from the world. The “asylum time” is slow and dead, removed from the pace of capitalism’s “productive” time. The asylum is “unproductive” time: patients wait for meals, they wait for treatment, they wait for death.

Sound is a trigger for Istina and the other patients/prisoners to stay informed about what is going on around them, all that is beyond their control from the ECT trolley to lightning storm. The asylum patients reside in an environment of hidden agendas and codes, and nothing is transparent in the ward, except for the sounds that interrupt institutional discourse. Nurses speak

sharply, and their words sting like snake bites (67). Frame emphasizes the imminent and predatory threat of the asylum and the necessity for keen survival skills, much like the skills needed to stay alive in the wilderness. Here, unlike the wilderness, one is caged, tied down and held prisoner. During the stressful ordeal of her first shock treatment, hearing the other patients be wheeled away screaming, Istina calms herself by reciting a poem and visualizing the face of her primary school teacher. Seasons are the metric of time for Istina, to locate herself against the erasure of time and memory. The natural soundscapes offer solace and spiritual grounding; they remind her of her mother's poetry and songs stands in stark contrast to the conjuring of the sounds of a Great Unreality. Madness is rendered *unreal*, all in one's head, like a secret knowledge or a way to perceive what is intrinsically hidden. Sound is a signal of potential danger, but also a source of soothing and groundedness.

From a phenomenological perspective, a question that persists throughout the novel is: Who is hallucinating? The patients or the asylum staff? It is also interesting to note how we, as humans, hallucinate sounds more than sights (Ackerman 180). If we extend the auditory hallucination metaphor to hearing voices, Istina may not be in a state of delusion when she hears voices; she is merely listening to the voices of the patients around her who are not being properly engaged by staff. Frequently, the patients are told that their imaginations are illnesses (24). Instead of seeing their imaginations as radical and creative solutions to complex traumas, as innovative ways to change their internal world and imagine it *otherwise*, the staff see imagination as a threat to the cure of civility. As the staff punish patients for existential reasons, because they sing too loudly when happy or start to cry when they are sad, it appears that they are seeing things that no one else can see, inferring that the staff misinterpret the patients' perceptions. "Radical imagination" is a concept developed by Castoriadis that says: "all this boils

down to characterizing psychosis in terms of creation—starting from an initial non-sense for the subject—of something meaningful for this subject that is non-sense for others” (129). This calls into question the madness of the misdiagnosing doctor or the patient who perceives the world through imagination and sensitivity. How do we receive the world of the speaker, the world we cannot inhabit with them? Auditory hallucinations, according to Castoriadis, work as a double: they are animatic solutions, created to vanquish what is unfamiliar and disturbing. They serve mainly to recover a sense of the familiar, and propel a vital force for the psyche to create a “new witness” (129). This new witness is able to bear the weight of the world that is far too heavy for the subject to bear.

We later come to know that Istina is not living with schizophrenia; she is living with the fear of not being able to survive in a capitalist-patriarchal-colonial society, a place that is harshly competitive and economically ruthless. She often thinks about how there is no way for a woman to survive without a husband; even with a promising career, she suffers economic hardships. In real life, Frame periodically checked herself into hospitals because she was afraid of not being able to cope with the stress of poverty. The asylum functions as an escape from capitalism, where one can exist outside of time and memory. Time is surveillance. Someone is always telling you what time it is and how you are meant to use that time. In the asylum, there is no free time and no free-will. Sound is also depicted as a mechanism of fear. The nurses use sound to control the patients, to scare them into submission. Whether by using gongs or loud voices, Istina is programmed to be afraid of the sounds around her, which usually signal punishment on the horizon:

Then the pegging footsteps as the massive Matron Glass on her tiny blackshot feet approached down the corridor, unlocked the observatory dormitory and stood

surveying us, with a query to the nurses, like a stockman appraising heads of cattle to go by truck to the slaughterhouse. (11)

The “pegging footsteps” foreshadow the “slaughterhouse” (coming to take patients away to Ward 2 for disobedience). Since Istina is always locked away or hiding, her perception is limited to sound, and so she witnesses through sound, developing “sound as a verb”. Focusing on the ear rather than the eye, Istina has a change in perception. The way she comes to know the world around her shifts, and this knowledge changes the materiality of the world around her: it is always winter, even in spring. Salome Voegelin, in her essay “The Ethics of Listening,” argues that centering the ear as the primary mode of perception changes the world around us: “And so it is different: its materiality, its status and what it could do, is enable in terms of understanding the condition and process of existing in time” (1). Even if listening is a way to stay safe from punishment in the asylum, being subjected to the terrifying sounds on a routine basis causes unnecessary stress for Istina. Sound remains a mechanism of fear that never ceases to startle and keep one uneasy. Psychological studies have demonstrated the negative impact of noise, sound pollution and loud sounds on the psyche (Ackerman 187). In most cases, such noise can lead to higher levels of cortisol production. Neurologists have suggested that it may be a relic of our evolution, when shrieks of terror alerted us to sudden doom. In Istina’s case, the constant exposure to loud noise, cries of terror followed by uncanny silence, are what drive her over the edge, towards her devolution:

Hearing other people threatened so often made me more afraid, and seeing that a patient, in the act of being taken to a single room, always struggled and screamed, made me morbidly curious about what the room contained, that overnight, it could

change people who screamed and disobeyed into people who sat, withdrawn, and obeyed listlessly when ordered Dayroom, Dining Room, Bed. (45)

The “Season of Peril” is described using the institutional rhythms and sonic panopticon of the asylum where power is held solely by the medical staff and patients live in fear. The ECT scene is akin to hostile violation, an intrusion on one’s body and psyche. Istina never consents to ECT; she is never asked what is best for her. In this era of medicine, during the 1940s, doctors and medical staff were all-powerful, holding patients’ fates in their hands. Istina is told to wait in a room, without any information or indication of what is about to happen. When she experiences ECT, it comes as an absolute shock. Because there is no patient-centered care or listening to patients’ needs or concerns, there is no transparency. Istina is constantly listening to hospital sounds, as though with a stethoscope, to figure out what will be done to her. As Dolly Mackinnon says, the asylum functioned as a place of diagnosis madness through “hearings” that were run by asylum medical staff. They used listening and observation techniques to distinguish the patients who were more on the sanity spectrum and those that were completely mad, and these modes of distinction were blurred with gender, class, and racial bias: “Within the confines of the asylum, noise, sound, and silence determined the boundaries between sanity and insanity – madness and reason, sane and hysterical women – the points of intersection were places of cultural confusion and clamour.” (81) Asylums were noisy even while madness was silenced through disciplinary power. From the perspective of the patients, as Frame elucidates, the asylum soundscapes are terrifying and confusing which can easily drive one to the point of severe distress and/or muteness. As Frame describes, the terror of sound builds, and Istina becomes more and more afraid of the sound of the trolley:

I continued to have ECT, dreading more and more the sound of the trolley and the stifled screams as it moved from room to room, nearer and nearer (...)

Suddenly I heard the familiar calamitous despairing cry of a patient undergoing ECT, and snorting noises in the room next door, and the sound of something being wheeled along the corridor to my room. (60-67)

In addition to Istina's fear of ECT, she lives in fear of being transferred to Ward 2. Patients who disobey orders are sent there as punishment. The disappearance of people in the night, the secrets behind closed doors and wards, leads to Istina's heightened ear:

You learned with earnest dedication to 'fit in'; you learned not to cry in company but to smile and pronounce yourself pleased, and to ask from time to time if you could go home, as proof that you were getting better and therefore no need to be smuggled in the night to Ward Two. (32)

Istina, like all the patients in her cohort, must listen to authority, and they must not talk back. "Treatment" is administered as punishment for one's subjectivity. Patients are not allowed to show emotion or have a voice. Istina mentions how one must listen to fit in, to figure out how to pass unnoticed, to survive and escape punishment. Uncooperative patients, who do not obey orders, who do not comply with the absurdity of institutional life, are given shock treatment or leucotomy to turn them into docile bodies, emptied of subjectivity and hollowed out of meaning.

In the context of memory erasure, recovery is impossible. There is no hope of patients returning home. A selfhood without memory is meaningless, because one is unable to locate oneself in the world. Frame uses the metaphor of a "homeless parasite" (18) to describe the disorientation of Istina's fractured selfhood after receiving ECT:

Then I rise disembodied from the dark to grasp and attach myself like a homeless parasite to the shape of my identity and its position in space and time. At first, I cannot find my way, I cannot find myself where I left myself, someone has removed all traces of me. I am crying. (18)

In this instant, we come to know how destabilizing this treatment is for her, how it confuses her mind and causes her memory erasure. This is what ECT does to her, or at least what it feels like. Thus, it is safe to say that “erasure” is not a compassionate miracle for Frame. She describes electroshock as an existential death sentence. And while others might claim it to be a treatment that saved their lives, I think it is important to consider how devastating this autobiographical fictional account is. Despite the imaginative sound metaphors, it reveals a grave mishearing of human suffering:

When I think of Cliffhaven I play the time game, as if I have been condemned to die and the signals have been removed yet I hear them striking in my ears, warning me that nine o’clock, the time of treatment, is approaching and that I must find myself a pair of woolen socks in order that I shall not die. (24)

Istina is still trying to find a way to protect herself against peril. The wind cuts, merciless and dangerously (here, electricity is symbolized as wind), much like the harsh words from the nurses. The ongoing emotional and physical abuse seems never-ending: it is always winter. No matter the season “outside” the asylum, “inside” it is always cold and dead. The symbolic weight of winter gives Istina’s account a hopeless tone. Life seems impossible in winter, when nothing can grow or bloom. The cold is stagnant, absolute and violent. Her prayers are mixed with safety measures, because praying might not be enough. She needs extra reassurance, because the asylum has her always/already terrified. While trying to remember what to do to protect herself

against electricity, she conjures memories of her father's rubber boots. Her attention to detail is intense and visceral, a strong depiction of family life, rural poverty, and perhaps her father's sense of humour:

But it would not come to my mind what to do when I was threatened by electricity, except that I thought of my father's rubber waders that he used for fishing and that stood in the wash house where the moth-eaten coats hung behind the door, beside the pile of old Humour Magazines, the Finest Selection of the World's Wit, for reading in the lavatory. (...) Lost in a foreign land, take your position from the creeks flowing toward the sea, and your time from the sun. (12)

This image renders erasure as an experience of being lost and not knowing one's way home. Istina remembers that when lost, she should use the natural rhythms of the sun and the direction of the water's current to locate herself in time/space. This is Nature's Survival guide: how to navigate in an unknown forest, on a fishing trip, off the beaten path. But Istina is in an institutional and foreign land where there is no hope of knowing where one is. There is no sun. One is forever lost in the sterility, homogeneity and "sameness". There is no way of knowing what day it is, or even what year. She must listen for clues. There is no way of knowing one's name. One does not have a name. One does not speak from that name in the asylum. Blank faces, looking out from windows onto the lawn and gardens. Istina observes the china cups that contain patients' false teeth. They are numbered instead of named, because names are meaningless: "the ink slips on the impenetrable china surface, and spreads, blurring from itself" (14). The intense alienation that Istina feels renders her not even unrecognizable, as no one can relate to her. She becomes nameless and without memory. Yet her rituals and superstition remain obsessive (ex. wearing wool socks during treatment to avoid death). She is still clutching to one's subjective

power, however imaginary or superstitious it may be. She is still holding on to fragments of free will:

Yes, I was cunning. I remembered once a relationship between electricity and wetness, and on the excuse of going to the lavatory I filled the bath and climbed in, wearing my nightgown (...) and thinking Now, they will not give me treatment, and perhaps I may have a secret influence over the sleek cream-painted machine with its knobs and meters and lights. (12)

Her effort to find “wool ward socks” (9) to keep warm, to defend against death, to protect herself from the “new treatment” and violence symbolizes Istina’s drive and passion for life despite the draining effects of electroshock that leave her feeling empty and cast off to nowhere, a “homeless parasite” (12). Listening is tied to resourcefulness, and Istina must struggle to survive and to remain herself. She listens to preserve a shield around her subjectivity, humanity, free will and agency in an institution that seeks to cure all the creative parts of her selfhood:

I was cold. I tried to find a pair of long woolen ward socks to keep my feet warm in order that I should not die under the new treatment, electric shock treatment, and have my body sneaked out the back way to the mortuary. (9)

Institutional listening manifests as compliance to rules and surveillance. ECT is depicted as a way to make patients more docile; after electroshock, they speak less and listen to orders. Thus, Istina observes shock as the new way of “quieting people” (9):

the new and fashionable means of quieting people and making them realize that orders are to be obeyed and floors are to be polished without anyone protesting and faces are made to be fixed into smiles and weeping is a crime. (9)

ECT subdues patients into a malleable pulp, perfectly molded to institutional rules. Gong sounds manage ward movement. Patients respond to the gong and position themselves, ready for orders. Nurses shout at them like drill sergeants. Auditory surveillance and medical listening indicate the presence of authority in the ward. The ward sounds are stressful for Istina:

Suddenly, from somewhere in the ward, a deep gong boomed again and again and immediately the whole ward seemed to come alive, as if the sound had disturbed the patients, like insects or flightless birds from their nests, and I saw people small tall fat thin deformed mongoloid dwarfed appearing as if it were from nowhere from corners and hiding places and with their little bags of treasures in their hands, hurrying and scurrying to the obedience to the gong. (72)

The treatment is designed to remove all agency, voice and spirit, quieting emotions instead of confronting, consoling, interpreting and learning from them. Weeping is a crime: here, we see the criminalization of emotion. Faces “fixed” into smiles symbolizes the harsh and inflexible methods of keeping people superficially “sane”, passively “okay,” but deep down they are still suffering an unnamable pain, something they don’t even understand or have a relationship with. The suppression of patients’ emotions also reinforces the idea that “negative” emotions are to be deleted, repressed or “fixed into smiles” instead of worked-through, engaged or negotiated toward new meanings. Sadness can be an opportunity to attend to a deeper wound, a silent cellular trauma, that one has never been given the language it needs to move through the body, to be spoken and released.

The ECT soundscape that Istina describes before and after shock treatment sounds nothing like therapy. What would therapy sound like? Perhaps, the beautiful songs her mother sings, the sounds of the ecosystem (birds, breeze and sea). ECT is always accompanied by

screams and disorientation. With each treatment, she is unable to remember what warranted the shock treatment. There is no consent. She struggles to remember what she had done “wrong” (9). While in Ward 2, “the disturbed ward” (12), she claims to hear noises of distress, suggesting the extent of pain resounding in asylum. Istina is in the sensible category still, not in the “noisy” ward. The sounds of patients’ slurred speech scares her into thinking her time might come: “Were we not the “sensibly” ill who did not yet substitute animal noises for speech or fling limbs in uncontrollable motion to dissolve into secret silent hilarity” (19). Perhaps the treatment is what stole their ability to speak, to use language in a coherent fashion. Most of the people on this ward have received leucotomies and hundreds of ECT treatments, so much so that they barely have cognitive function. All of the permanent patients live in Ward 2:

We heard them as background noises from their special park and yard and at night when their sleeping quarters, known as the Brick Building, became like a hive of bees wailing and screaming behind the rusted wire-netting windows, as if their day’s honey had been lost or never gathered. (36)

What can their perception of the world be from behind rusted wire-netting windows? The sound of treatment on this ward is “stifled choking scream” (13). Here, Istina reflects on how the experience of erasure/unconsciousness is equivalent to loneliness: she no longer has thoughts or an imagination to keep herself company. After this scene, she goes back to nature metaphors; trying to locate herself in the forest/foreign land, trying to find her way home despite the memory erasure. Weaving the survival-camp dream imagery with the asylum, she is in/out of consciousness, lost in a displaced selfhood. She imagines that the ward might be the training

ground for Sing Sing's electric chair (16). Istina's "Season of Peril" is an example of how the asylum functioned to forget/erase deviant bodies from time. The screams behind closed doors sound: "convulsed and snorting" (16) are reminders that in order to survive she must listen to orders. Her rituals to stave off death, to count the seconds before treatment, to hold on to a sense of time is what preserves her sanity/agency.

In losing one's memory, one loses the tools to communicate with legitimacy. After ECT, Istina describes her mind as a scarred landscape, devoid of living plants. The image suggests the futility of her efforts to save or preserve any of the landscape; her memories will be burned in a raging forest fire. She describes this lost voice as lost tools and a scarred landscape with no hope of regrowth. She remains desolate and barren:

It was early in my dream. The tracks of time crossed and merged with head on collision of hours a fire broke out blackening the vegetation that sprouts a green memory along the side of the track. I took a thimbleful of water distilled from the sea and tried to extinguish the fire. I waved a small green flag in the face of oncoming hours and they passed through the scarred countryside to their destination and as the faces peered from the window at me I saw they were the faces of the people awaiting shock treatment. (13)

The violence of memory erasure is palpable, Istina no longer has the cognitive tools to make-meaning that will console and soothe her constant fear/anxiety of disaster. Istina describes the phenomenology of memory erasure as being like a "like a surgeon without his tools" (30). She feels robbed by psychiatry, and no one can be held accountable. Memories are immaterial, invisible and constantly changing—yet they are important meaning-making tools. It is near impossible to prove when the memory of a person has been stolen or erased; only the person

affected can know. This highlights the problem that most ECT survivors confront when attempting to share their stories. This is a powerful description of what ECT does to the person's sense of self and their ability to communicate. Patients are lobotomized. They never get out. Straitjackets and brain damage keep them prisoners for all time. Their cells are held prisoner, the very essence of their atomic being: "Atoms in prison dress revolving and voyaging, if that were possible, in search of their lost nucleus" (77). However, what is fascinating about Frame's use of the word "nucleus" is that it can also refer to phonology, where the nucleus of a syllable is the most sonorous part of a word (Anderson). Thus the nucleus with the most sonorous sound carries the most acoustic energy. Frame might have been alluding to the patient's desire to reclaim their lost acoustic energy that has been muted by the asylum's sonic panopticon. Beneath the surface of Frame's language is a sounding impulse for liberation.

Throughout the novel, Istina fears becoming like the empty vessel humans she sees in the dayroom waiting for shock treatment or staring blankly out the window. Into nothing. There are no thoughts to keep them company (13). Istina often forgets that she is no longer a school teacher, a career she had before entering the hospital, and that she has been in the asylum for eight years (13).

The doctor's hospital "rounds" are rituals in pretending to listen to patients and pretending to care about their endeavors to pass the time (20). Patients have no ambitions, they are basically waiting to die, so the whole production of asking them about their macramé and needlepoint, as if it were their passion and drive in the world, is completely absurd. It is patronizing. The optics, however, gesture toward compassion, Dr. Howell seems to endorse the "new attitude" of patient-centered care. He is young and fresh-minded, and he has the latest trendy developments in medicine available to him. He knows about occupational therapy and

other “alternatives” to the hopeless lock and key. Istina describes the excitement that he brings to the ward: “It was the youth of Dr. Howell which appealed to us” (22). After being surrounded by death, Dr. Howell brings hope that mental health care can be humane, as he advocates for leisure and occupational therapy. He believes mental patients were people, not cattle. In *The Birth of the Clinic*, Foucault seems doubtful of these staged “encounters”. He describes how the very “idea” of doctor-patient relationships is stifled by the language of rationality and the medical gaze:

The mindless phenomenologies of understanding mingle the sand of their conceptual desert with this half-baked notion; the feebly eroticized vocabulary of “encounter” and of the doctor-patient relationship exhausts itself in trying to communicate. (ii)

A meaning has taken shape and hangs over the doctors’ and patients’ heads, preventing them from speaking from a “free” subjective position. They have already been written into the story of their relational transaction, and anything beyond this structure is erased, forgotten. Their training in the “new attitude” is meant to enhance consistency and effectiveness of care, by providing doctors with the scripts to systematize communication, and, in essence, to avoid error. One can understand the need for such paradigms: doctors’ care can make the difference between life and death, which demands ethical integrity and consistency. However, death is the ultimate inevitability, beyond all error. Despite stressing the need to treat patients as whole persons, the “new attitude” depicted by Frame is very similar to contemporary legislation of patient-centered care. The weight of professionalization has positioned the “care plan” before the patient—thus silencing the patient’s speech even within a “plan” that claims to encourage feedback and teamwork. “It was Dr. Howell who tried to spread the interesting news that mental patients were people and therefore might like occasionally to engage in the activities of people” (22). But in

fact, like all doctors in the asylum, Dr. Howell is managed by the nurses, who say he is “too ‘busy’” to listen or answer patients’ questions about when they can “go home” (24). The patients crave a sympathetic listener; they are hungry for recognition. Within the economy and hierarchy of care, an assembly line is formed, where attention is distributed mechanically to each patient. The nurse-nuns (Matron Glass and Sister Honey) bitterly and purposefully interrupt the interaction between the doctor and patient. Although Istina does not know why, she describes these interruptions as the nurse-nuns aiding in maintaining Dr. Howell’s distance and allowing his exit from the caring scene:

Then giving a troubled guilty glance around the dayroom, he would retreat for the door while Matron Glass and Sister Honey attended to the mechanics of his exit unlocking and locking the door and keeping at bay those patients whose need to communicate to a sympathetic listener made them hurry forward in a last attempt to show their tapestry or hurl abuse or greet-and-demand with Hello Doctor, when can I go home? (22)

Dr. Howell is in a “privileged position” (22), above the patients. Istina describes how he drinks from a “special cup” to distinguish himself from the rest of the staff and patients and to prevent the spread of “diseases” (20). Much like today’s neoliberal hospital, there is no time to listen, because time is an expensive resource. Listening costs too much money. The doctor sometimes grants a patient sitting in the dayroom with a brief greeting, “but at the same time glancing hastily at his watch” (20), not paying attention, giving only a superficial portion of his time. The way Istina describes the scene, it seems like a parade, where the doctor (almost like a celebrity or god) tours the ward as a symbol of medical authority, scientific rigor and legitimacy. But he could not be further away from the trenches of care (21): he hovers above the patients and nurses

(who are all female) as they breathlessly compete for his attention, for the slight chance of being asked to speak:

The patient chosen for conversation with the doctor would become so excited at this rare privilege that she sometimes didn't know what to say or else began a breathless account which was cut short by Matron. (21)

Condescending and disrespectful, the nun-nurses dismiss the patients who seek the doctor's attention—whatever the patient says is not very important. It is simply seen as silly, a waste of time: “Now Doctor's too busy to listen to that, Marion. You get on with your fancy work” (21). Speaking is regarded as a disturbance to the doctor. The nurses uphold the medical hierarchy more than the doctor, and it is suggested that perhaps Dr. Howell did not *choose* to be in this revered position of power. The asylum makes him uncomfortable. It is unsightly to witness. As the Matron Glass (head nurse) shoves aside Marion, a lonely patient, she apologizes to the doctor by saying, “She's been uncooperative lately. We put her down for treatment tomorrow” (21). The nurses are bullies; they seem to hate the patients, most likely because they live and work with them so closely. The doctor is behind the glass door, watching them from his chart. He does not touch them; he does not get too close. He is scared, but also ashamed. He does not perform ECT: a team of nurses does it.

All of these scenes boil down to uneven power dynamics that impede genuine and compassionate listening, which we still see today in contemporary psychiatric care. For example, The College of Nurses of Ontario (CNO) has a statement on “power” within the psychiatric nurse and patient relationship, it defines the term as a homogenous, flat entity that only the nurse can administer: “The nurse-client relationship is one of unequal power. Although the nurse may not be aware of it, the nurse has more power” (College of Nurses Ontario, “One is Too Many”

4). Power, here, becomes something that psychiatric nurses hold exclusively, as if it were a direct embodiment of medical ideology. Nursing students are taught to feel solely responsible for the patient's recovery, which can have devastating results for thinking about the sharing required in ethical forms of communication. Absolute power feeds absolute knowledge and it leaves no room for listening to a story otherwise, or even subjectively. Critical of this absolutist approach, Foucault's articulation of power counters tyrannical ownership. He writes, "Centers of power form multiple segments linked to one another which the individuals of a mass traverse or inhabit body and soul" (Foucault, *Discipline and Punish* 23). Power is thus a matrix, intricately in flux, producing possible relationships and reality before it represses that reality. Such "reality" is never stable or true without a power-knowledge dynamic to organize it and make it true. Therefore, the discursive power-knowledge dynamic of the psychiatric training manual that names the nurse as the sole executor (or dictator) of power in the therapeutic relationship creates a false truth. The statement that nurses "have more power" (CNO 4) than patients seems redundant and obvious—almost absurd, since, according to Foucault, power is never unified and homogenous, but rather relational, functioning in a web of historical, social, political and economic exchanges. Of course, the nurse does have power, but such power is never without history. Even naming the patient a "client" reinforces the transactions of capitalist power based on a demand/supply economy—therefore, "clients" have power too. They can refuse treatment. They can threaten the nurse and the medical institution. They can bring their business elsewhere. They can die. Under these specters, nursing pedagogy understands "power" in simplistic and overt ways—and naming these power-relationships in such a way silences the very possibilities to change the discursive dynamics they produce. Power is about change, as well as repetition—and history, more importantly, forgets these power relations in order to repeat them elsewhere.

From a historical perspective, we see in Frame's novel how the "new attitude" (mental patients are people, like you and me) spreads as a less invasive mechanism of power—it operates under the guise of care but aims to ultimately control patients' individual time and agency. Occupational Therapy is introduced slowly, and the concept that leisure and meaningful activities for patients can have a healing effect starts to become important. The language shifts in this moment as well: the optics of the "asylum" must be transformed into "psychiatric unit" (61). Calling it something "new" (new attitude) erases the traumatic history of the asylum (similar to the language of lived experience engagement), and it sterilizes the truth:

[T]he doctor would nod absentmindedly, make a fatuous remark and because of his intelligence immediately realize the fatuity and mentally step back from himself like a salesman who has slighted his own wares. (21)

The PR machine of healthcare operates to distance staff from having to take responsibility for their guilt. Re-thinking the doctor's "guilty glance" as a means of escape, according to Sharon Todd in *Listening to the Other*, allows for guilt to be an opportunity to take responsibility, perhaps even to change attitude; but in his case, it is defeat, resignation to a hopeless view. These patients were never going to be viewed as worthy of respect. Despite being a part of the "new attitude" of psychiatry, Dr. Howell wants to keep his distance, to stay on the other side of the wall. He cannot risk listening to these women's stories, as that would bring him too close: he would be brought into relationship with immense anguish, and he would have to believe them.

To appease guilt and to deflect from engaging with patients authentically, Dr. Howell promises patients they will be going home soon (21). The promise of going home is cruel; it seems like a patronizing way to silence patients' questions. These patients have no home to return to. Home is nowhere. They are a social burden, kept away and hidden like bad news

mostly because the psychiatric care system does not believe in recovery or in the patients being able to live meaningful lives. Istina says after her first “assessment” that her personality is “condemned like a slum dwelling” (12). This suggests that even her personality is uninhabitable, and she is homeless, existentially, both inside and out. ECT and lobotomy promise to bulldoze the “slum dwellings” that all the patients inhabit, much like city developers who demolished the homes of the poor to make room for market-based constructions. Condemned to be erased like the neighbourhoods she grew up in, Istina speaks about this as a symbolic death: although it might not be the end of life, it is the end of meaning. Homeless both physically and existentially, utterly starved for attention and meaning, they find meaning in the meager mundane interactions they receive. Even in the banality of a greeting they sway; they will romance a “hello” because they have been deprived of dialogic recognition. “But when you are sick you find yourself a new field of perception where you make a harvest of interpretations which then provides you with your daily bread, your only food” (23). This is an example of what sensory deprivation does to the brain: when you are so desperate for contact, you will live in the world of imagination to compensate for a horrible reality. Istina compares the nurses to poisonous insects and snakes, highlighting the sounds of metaphorical deceit. The doctor makes small-talk asking patients if they were settling in. The logic of “settling in” inside an asylum is jarring on many levels. The word “settled” conjures the colonizing effects of brain-washing, strategic erasure to be able to inculcate a new message, and to disempower the colonized from making-meaning or speaking for themselves. Patients must submit to a new way of life, one that does not disrupt the new economy of care:

‘Settling in?’ the doctor would inquire from time to time, as a passing breeze from another country might address an animal which it happened to catch a sight of

preparing for hibernation. The act of 'settling in' was surrounded with approval:
'the sooner you settle the sooner you will be allowed home was the ruling logic.

(34)

The nurse berates a patient having emotional difficulties by saying, "If you can't adapt to living in a mental hospital how do you expect to live "out there" in the world?" (34). To settle in and adapt, Istina must hide. She must suppress her existence. To preserve her safety and selfhood, Istina hides in the linen cupboards to listen and to cry. This tactic will protect her from being "written up for ECT" (26). To be seen crying would result in punishment, so she hides. From this secret place, where she can express herself in peace, without the fear of being reprimanded, she also closely listens to the TB patients, those who are utterly hopeless. The TB patients are tucked away from sight, therefore the linen closet on their floor is the safest place to hide. The TB ward is also the most depressing ward, where patients look like ghosts—barely alive. When they die, their "bodies are hastily and antiseptically dispatched to the mortuary"(26). The mortuary has no name and it is hidden behind the laundry facility. Patient names are not written on graves; their bodies are disposed of, burned and never mourned. Even in death they are dehumanized and erased, made to take up less space and obey orders:

If the mortuary were built in proportion, to really house the dead, its size would swallow the greenhouse and the laundry and the boiler house and the Big Kitchen, perhaps the entire hospital. But it is small, unobtrusive, and begs that patients conform to the rule of loneliness by dying one at a time. (27)

This remark exposes the asylum as a place of death, not of healing, and not of recovery. It is where people go to die forgotten and dismissed. Istina feels as though she is listening to the dead. While in the linen closet, Istina reflects on a patient, named Margaret, a TB patient who has

PTSD from the First World War (although, at the time PTSD did not exist within medical language, shell shock was the closest term and it was only reserved for soldiers, not war victims or witnesses). She speaks in a hoarse whisper about the “enemy in her room” (26). She is stuck in a memory loop from decades earlier. The nurses dismiss her repetitive whispers as they change her bedsheets. But to Istina, her story, told like a broken record, must be received and heard. Istina observes and hears how Margaret desperately wants to tell someone, anyone who will listen. She still sees the enemy in her room, and believes he is there waiting to hurt her. Isolated in a room with no sun for years, trapped in the trauma of her memory/imagination, Margaret embodies a liminal space between the dead and the living. Istina thinks that she appears to be dead, and she is described as translucent as a ghost. Listening to Margaret requires Istina to suspend logic, and welcome an imaginative relation, as Castoriadis suggests: “listening requires an initial suspension of a socially prescribed logic. What we hear is not a transparent representation of an unconscious entity but a movement of signs through which a subject makes meaning for herself” (129). Istina must renounce the certainty of understanding, she must welcome what cannot be known about Margaret, how the parts of her that speak are, unconsciously and strategically, concealing the larger story. Fittingly, Istina comes to this realization while hiding from nurses on duty:

The linen cupboard is my favourite hiding place. It is scrubbed every morning by the TB nurse and the floor looks like the deck from a ship. From here I listen to Margaret who has TB and whose hoarse whisper tells continually of the First World War. She pleads with anyone who passes in the corridor to help her evict the enemy from her room. (26)

The linen closet, where time stops, is a microcosm of safety and controlled listening. It is a place where Istina can feel grounded, undisturbed, and where she can remember. It is a place where she can imagine and dream and weep and engage with her trauma of ECT. It is where she can find herself, ground herself, listen to her own bodily rhythms and breath:

I know that the linen room was very often my sanctuary. I looked through its little dusty window upon the lower park and the lawns and trees and the distant blue strip of sea like sticky paper pasted edge to edge with the sky (...) I wept and wondered and dreamed the abiding dream of most mental patients—The World Outside, Freedom; and foretasted too vividly the occasions most feared—electric shock treatment, being shut in a single room at night (...) (30)

The function of the linen closet is to help Istina learn how to listen to her own thoughts without judgement. It is a safe place to listen to herself and to others. During her stay in the asylum, Istina learns to repress her feelings; she learns to listen to authority and to do as she is told. Getting better means getting quieter and quieter.

In addition to her fear of freedom represented by the linen cabinet, we encounter an ambivalent image of the sun. It illustrates both the hope and hopelessness of one day getting out into the world. Later in the scene, Istina observes how the sun makes its way through the “rusted netted window” (26), suggesting that a new way of seeing things emerges. Some ray of hope shines into a dark mind. Yet there remains a spatial hopelessness. The space in which these women are held is not conducive to seeing things in a different light. The space depresses as it oppresses and forbids sunlight. The sun is later illustrated as menacing (30), threatening to melt the road to success (a highway of glass which in itself would be a precarious route). Istina has lived for many years in this room, seeing the sun only for a few hours on a summer afternoon

when shafts of light manoeuvre their way through the rusted wire netting of the window to shine and set the motes dancing on the wall (26). As Frame describes:

(the sun) rose higher in the sky its tassels dropping with flame threatening every moment to melt the precarious highway of glass. And the people: giant patchworks of colour with limbs missing and parts of their mind snipped off to fit them into the outline of the free pattern. (30)

Minds snipped to fashion people into productive and happy workers on a precarious highway of glass is an unsettling image. Despite this modern attitude of “new psychiatry”, Istina has seen and heard too much to trust doctors’ promises of returning home or a returning sun. It was always winter, and Istina spent her time eavesdropping on the punishing plans of the ward staff: “But I was attacked increasingly by disquiet; I had seen, as it were, the sliding panels, overheard the sinister conversation” (66). Overhearing the “sinister conversation” (66) leaves Istina paralyzed. She is unable to settle into herself because the threat of punishment is always looming in the background. Trust is impossible, thus hindering her chances of recovery.

Janet Frame’s unconventional use of grammar highlights the discrepancy between voice, memory and time. She symbolizes “memory erasure” with her psychedelic prose that skips through time compared to the rigid grammar of the institution that manages patients’ experience of time. Frame’s writing mimics transition without recollection, paragraphs end suddenly and start in abrupt new time and location. Time is a major concern for Istina, with “asylum time” punctured by cognitive lapses and strict routines that stutter in between her recollected story. Istina and other patients are constantly waking up in another time/space, in strange unworldly dimensions, illustrated by the perpetual and uncanny confusion about the seasons. In the *Time of Memory*, Charles Scott, describes how within the act of remembering there is always a jarring

aspect to narrating what one *remembers* and what *is* (120). To make this concept come alive, Janet Frame's unconventional use of grammar disrupts the time of the asylum. In this sense, I call her prose *psychedelic* in that it induces a trick of perception, a sort of linguistic alchemy that shifts reality towards something more promising: an unconventional expression that subverts the limitations of being imprisoned in a time one does not remember or feel connected to. Time, like memory, cannot be measured or captured by a constant. The asylum is conducive to erasure, alienation and confusion precisely because it is as rigid as grammar. It is a language that will not bend to basic needs. Through her loss of subjectivity, she transforms her language. Istina stops punctuating her sentences, stops signaling time. Her writing drifts into free-form, and the past-present-future are all forever being lost at sea, like a dreamlike oceanic experience. Time just washes over her. Frame's unconventional grammar and lack of punctuation signal a free flow, a stream of consciousness in her writing/voice. Istina speaks directly to the collapse of time and memory:

There is no past present or future. Using tenses to divide time is like making chalk marks on water. I do not know if my experiences at Cliffhaven happened years ago, are happening now, or lie in wait for me in what is called the future. (29)

Again, themes of being displaced in time/space due to memory erasure relate to feelings of homelessness and selflessness. We see how memory erasure affects one's ability to know oneself, to find oneself, and to measure one's existence (or improvement) in time-based chronology (29). It disrupts one's internal grammar, one's ability to make sense of their lives and to articulate what happened to them coherently. There is no progress, no sense of moving towards something new and hopeful. Repetition of not knowing what time it is, what day, what year happens stylistically and grammatically (29). The future is a foreign concept, an

unknowable horizon (29) like the distant blue strip of sea, or the “Outside World” that the patients cannot imagine.

The unknowable horizon of the outside world, beyond the asylum walls, is probably the most obvious limitation these patients face. They are also confronted with the impossible dream of ever experiencing love, for oneself and for another. As ECT has damaged Istina’s brain, she is unable to get out of “the dream” she is permanently hallucinating or stuck in the “Unreality” (4). “Love” is a crab with a rainbow shell and pincers that walked sideways getting nowhere, which symbolizes how inaccessible and impossible it is to hold onto.

In spite of this ongoing hopelessness, Istina becomes a beacon of light and warning, mobilizing sound and listening to protect the other patients from harm. Her listening skills are survival skills, and she listens to warn others of upcoming danger. Those who have been subdued into a vegetative and medicated state no longer have anxiety as a healthy drive to preserve the ego. Istina’s reclamation of cognition and power are animated with sonic metaphors: the sound of thunder and the image of lightning. When Istina finally makes it to Ward 7, the privileged ward, where the most “sane” reside, she listens to the differences. This is the ward of fashionable madness, the artistic kind. They do not speak about their symptoms; rather they are nostalgic and dreamy. Istina recounts the erasure of patient’s lives outside of the asylum: “I heard no one talking of their families or their nervous breakdowns and its symptoms; it was obvious that eccentricity was either not realized or else accepted, as the way of life in the ward, and certainly not discussed” (45). Sounds and listening measure safety and freedom and Istina hears the difference between spaces within the asylum: in this ward, the patients are allowed to visit the garden and to listen to the radio each night.

Unfortunately, her time in Ward 7 is short lived. She is soon transferred to Ward 4 and then back to Ward 2 for being disobedient. She describes Ward 2 as sucking the life out of her, eroding every bit of her will. This kind of existential erosion is depicted by rotting meat in the sun, carnivorous flies stealing the last of her oxygen, the natural process of decay. The environment is not one in which a being can survive. In Ward 2 she is denied pants, and at this point, she decides to speak up: “I wanted the peeled layers of human dignity to be restored, as in one of those trick films where the motion moves backwards, so that I could see beneath the surface” (79). She starts to “make a fuss” (79) to demand her rights, at the very least a pair of pants that fit. She also begins to stand up for others who cannot speak, who are in straitjackets or are mute. Istina decides to be their voice. Speaking and animating sound is just as important as listening and receiving sound, and is crucial for emancipation:

I was shocked once to find myself without pants. I made a fuss. I was becoming adept at making a fuss, at arguing and trying to stand up for my rights and the rights of other patients whom I felt the responsibility of protecting. I complained loudly, “I’ve got no pants!” I thought of Ward 7, its brightness and kindness and the gently melancholy patients talking of their aches and pains and not being able to sleep and suffering all the sweet irritations of consciousness; talking too of home and relatives and plans for the future; everything seeming so tidy and certain and safe. (81)

The humiliation of not having pants and having to put up a fight for basic dignity leads Istina to imagine a blanket of snow muffling patients’ voices. This sound-image quite powerfully illustrates the effect of silencing and the way in which it accumulates over time until one is completely buried and forgotten. When Istina says the snow is “deadening the sound of our

lives” (81) and “if a tomorrow ever came it would not hear us” (81), she illustrates the endless cycle of Foucault’s notion that madness cannot speak. Tomorrow is the possibility to be heard, but tomorrow does not exist for someone who is buried alive. She feels like the entire world has “given up” on her and her cohort:

And the days passed packing and piling themselves together like sheets of absorbent material, deadening the sound of our lives, even to ourselves, so that perhaps if a tomorrow ever came it would not hear us; its new days would bury us in its own name; we would be like people entombed when the rescuers, walking about in the dark waving lanterns and calling to us, eventually give up because no one answers them; sometimes they dig, and find the victim dead. . . . So time was falling upon us, like snow muffling our cries and our lives, who would melt it for us. (82)

The only way to escape winter, the impending death and doom, is to be heard. Diane Ackerman in *A Natural History of the Senses* describes how “absurdity” (in Arabic) means not being able to hear (175). She goes on, “To lose your sense of hearing, a crucial thread dissolves, and you lose track of life’s logic” (175). To be heard and to hear thickens the sensory stew of our lives, and we depend on them to help us interpret, communicate with and express the world around us. Biologically, hearing “bridges the ancient barrier between air and water, taking the soundwaves, translating them into fluid waves and then into electrical impulses” (Ackerman 177). This transformative act is a form of radical hope that Istina holds onto. Being heard would melt the snow and break down the communicative barriers Istina faces. Listening with compassion would create a relation that could give the patients hope of recovery. It could restore a therapeutic bond and capability for existential dignity. In order to resist being buried alive by the snow, Istina

listens to the environmental sounds instead of the sounds of the asylum. To vanquish the sinister whispers that plan to give her shock therapy as punishment, she imagines listening to the ocean tides falling on a beach. The sound of an engine shunting and tides falling upon the beach, as if a private ferry were in operation with the bodies being taken from shore to shore (84). But her imagination can only go so far. Her fear of lobotomy, to be turned into a strange mute animal, grows every day:

I could no longer control my fear; it persisted and grew stronger and day after day I made myself a nuisance by asking, asking if they were planning to give me ECT or to do anything terrible to me, to bury me alive in a tunnel in the earth so that no how long I called for help no one would hear me, to remove part of my brain and turn me into a strange animal who had to be led about with a leather collar and chain wearing a striped dress. (86)

Convinced she will be murdered with electricity or leucotomy, she is distressed from the abuse and patronizing treatment. She grows violent. She attacks the nurses. Her anger consumes her in a negative way to the point of desiring suicide. Istina attempts suicide by “stealing tablets” (180). She writes a letter to Death. The nurse-nuns catch her, and she is resuscitated against her will:

I wrote to death: Dear Death, I said formalizing our relationship (...) Then a stomach pump, black coffee, before I slept, screaming and screaming at Sister Bridge (...) then sleep in seclusion. (180)

While in seclusion, she is denied reading materials so Istina recites poems to herself to cope with the boredom (183). Poetry reminds her of her mother, it soothes her anxiety and brings her back to herself. In a sense, her suicide attempt can be understood as an expression, a way to speak and be understood. It is a symbol of her will to live otherwise, in a different world that would accept

her as she is: “I knew they were hiding the truth from me, refusing to tell me the fearful plans they were making. And I had to know” (86). Out of nowhere she is transferred back to Ward 7, which means she has recovered enough, has quieted. But she will not forget the trauma she experienced in Lawn Lodge; she carries it like bank-notes. To know how her resources were spent, and who took what within this economy of imprisonment in the guise of care:

I do not know, I cannot remember when it happened that the nurse came to fetch me, saying ‘You’re being transferred to Ward Seven’, but I found myself wandering once again the garden with my experiences in Lawn Lodge like the bank-notes that you are told to put in small bags. (107)

All of her transfers happen as if by dream or transcendence. She has no mental record, no timeline. She just woke up as someone new. Frame’s writing mimics this transition without recollection; paragraphs end suddenly and start in abrupt new times and locations. But the fear is constant. Her distrust in the system is permanent: “I was permanently afraid now and full of disbelief” (107).

The Faces in the Water: Frame’s Ethics of Listening Otherwise

In this section, I engage with the sonic landscape of inner-listening and dialogic listening in the novel. The asylum soundscape is one that defined and managed madness; sound was used to differentiate between those thought to be sane and those seen and heard as insane. Patient sounds and gestures defined their otherness and the interpretations of their sounds by asylum staff as “other” normalises the listener (MacKinnon 77). Frame, on the other hand, subverts this dynamic of interpretation and urges a form of ethical listening that restores the patient’s existential sovereignty. To do so, Frame uses the image of “the face”, similar to Levinas’ concept, to

suggest a civic responsibility towards a response, a communicative gesture of compassion that risks vulnerability. Being able to listen self-reflexively and dialogically is crucial for creating an ethical bond which troubles the authoritarian dominance of psychiatric listening in the “Season of Peril”. Engaging with “the face” through listening to its submerged speech underwater is a way to subvert the power of psychiatry that silences madness.

“The face” is an important image in the novel. Frame uses it as a metaphor for the human, with the “face” symbolically warning against systemic dehumanization processes. We encounter “the face” as a powerful metaphor that provokes and contests this slippage, in several instances. One of the ways Istina attends to the alterity of the Other is through listening, without trying to understand, but simply holding-space for the Other to be. The first encounter with “the face” is when Istina, in a dream sequence prior to being hospitalized, sees patients being transported to Cliffhaven by train. They make eye contact. She is afraid and perplexed. Their faces contradict the ideology that these people are unlike her. Their faces humanize them, even if they are nameless and wearing prison-like smocks. The face is an image that startles, forcing her to engage and be in relation to the Other. It makes her question her own discomfort with madness and how she can take responsibility to advocate for those who cannot speak for themselves.

I waved a small green flag in the face of the oncoming hours and they passed through the scarred countryside to their destination and as the faces peered from the window at me. I saw they were the faces awaiting shock treatment. There was Miss Caddick, Caddie, they called her, bickering and suspicious, not knowing that she would soon die and her body sneaked out the back to the mortuary. And there was my own face starring from the carriageful of the nicknamed people in their ward clothes, striped smocks and grey woolen jerseys. What did it mean? (13)

This dream sequence of faces foreshadows Istina's eventual arrival at Cliffhaven and memory erasure by ECT. Seeing her own face superimposed onto the patient faces who are awaiting shock treatment symbolizes her similar fate. Her memory skips from past-present-future, and is off-track, from ECT like the "tracks of time merged and with a head-on collision of hours a fire broke out blackening the vegetation" (13). This is an example of how Frame flattens time/space, weaving future knowledge into recollection. As the passage illustrates, she sees her reflection superimposed onto the faces of the asylum inmates as a foreshadowing of her future fate of ECT's memory erasure. Istina sees the face of Miss Caddick, as it was before her death, and knows she will soon die and her body will be erased from time. The asylum remembers no one. Frame finds affinity in the lost patients, those who no longer have the means to speak in coherent grammar or gestures, those whose names have been replaced with Ward nicknames, whose memories are erased by the perpetual winter.

Encountering the face is to encounter one's own vulnerability which is something that psychiatry in this novel refuses to do. Earlier in the novel we see the face "fixed into smiles," unable to weep. Encountering vulnerability through the Other's ungraspable alterity is a mechanism to build compassion within psychiatry. In line with Emmanuel Levinas's views in *Totality and Infinity*, the singularity of the face directs our attention to the universal that we can never escape; we are forever indebted and responsible before the infinity of the Other. This relationship to the face (the Other) connects us back to the whole, the unknowable infinite complexity of the universal that we must remain open to receiving through a "quiet listening, vigilant against its own interference, cautious of its own interference, careful not to disturb" (21).

Frame centralizes a lesson in permanence: Istina is now ideologically and culturally marked (stigmatized) as a hopeless case. When Istina's face merges with those of the asylum,

she is indistinct, becoming a permanent citizen. All throughout the novel, pre-asylum, she felt homeless and out of place, but now she is a citizen of a place she does not identify with. She has been shaped to fit into it, or “broken into” it, like a wild mare given the thickest bit: “I was in the crazy world, separated now by more than locked doors and barred windows from people who called themselves sane (90). Frame in this instance is inverting the word “crazy” to symbolize how social conventions and constructed norms create insane conditions for beings to adjust to, which results in madness. The institution upholds “sanism” in completely insane ways, thus reinforcing the artificial binary between sane/insane: but so does everyday society. Institutional “sanity” is produced through elaborate discursive formations that obscure its very existence as a political tool. The “people who call themselves sane” (90) are sane because they have not been marked with the stigma of madness. Sanity, by this technological logic, is described by the absence of madness. In contrast, Philips attempts to describe sanity in a more robust manner, by getting at its ethical possibility. For Philips, a more useful understanding of sanity would be to interpret it as the ethical responsibility and courage to ensure the world is a good place to live for everyone who inhabits it. Sanity would prioritize caring relationships that uphold compassion and dialogical difference. Philips writes, “For the deeply sane, whatever sanity might be, it is a container for madness, not a denier of it” (180). By recognizing madness as a symptom of being alive in the world, we can reconnect to the ethical gesture of sanity. Sanity is not found in the brain like a tumor, described with absolutes, nor is it a gene we are born with. Rather, it is a state of being *for* each other and *with* each other. It describes what we are made of, instead of what we lack.

Sanity in fact, is a verb, and for Philips it should prevent humiliation (199). To engage with the face of the Other is thus “sane” by Philips’ definition. When Frame writes of “this crazy

world” she is referring to the asylum, but it can symbolize Western colonial society at large, because the codes of the asylum are merely exaggerated social norms found in everyday civilian contexts. On the contrary, sanism, the discursive idea that to be “sane” is to be without madness, is everywhere and goes unnoticed, thus reproducing “normalcy” from both inside/outside the asylum.

Another instance where Frame uses “the face” to symbolize the need for ethical engagement with the Other is when Brenda, the leucotomy pianist, sees her face in the dayroom piano. The reflection is a trigger to a past self that was on a path of fame and prestige; now lost and living in an asylum, Brenda has little dignity left. We first encounter Brenda when Istina is transferred to Ward 4. She is reacquainted with Brenda after years of not seeing her, in Ward 2 (the troubled ward). At first, Istina notices the “change” in Brenda, reflects on how she had once been a brilliant pianist and now Istina “tries not to weep” (129) at the sight of her condition. Brenda recognizes Istina and recognizes the piano in the dayroom. She sees her reflection in the piano, as if “it had begun to pay her compliments. It shone ebony; she could see her face in it, even the shadowy hint of her dark moustache” (129). Despite being completely disoriented by the leucotomy and unable to speak coherently, Brenda still can see herself “in the piano”. A part of her will always remain instinctively a pianist, and this is the portion of her psyche that can still speak through the language of music.

As MacKinnon describes, while music was used as medicine in many asylums, it was also used as an “aesthetic restraint” (93). Patients were not encouraged to play their desired music or to express themselves creatively, rather they had to play “appropriate music” (94). Frame also describes this phenomenon. By popular request, Brenda begins to play “Always Chasing Rainbows,” adapted from Chopin (Fantasie-Impromptu). A biopic of Chopin’s life A

Song to Remember (1945) was popular at the time. The song itself is a metaphor for the patient's dream of one day being free, of one day experiencing a state of contentment and inner peace. But reaching the end of the rainbow, where happiness exists, seems impossible. The narrator in the song questions if they are a failure for not reaching happiness or if the world is to blame for their troubles. The song reflects Brenda's situation: listening to Brenda play makes Istina uncomfortable and she feels guilty for having not saved her from Ward 2, for not having done enough to prevent this tragic loss of talent and selfhood. Before Brenda can finish playing the song the nurse quietly interrupts to put a stop to the music because it seems to be upsetting the other patients:

At first Brenda played lovingly, remembering every note, although her sense of time seemed to have suffered (...) Listening to her, one experiences a deep uneasiness as of having avoided an urgent responsibility, like someone who walking at night along the banks stream, catches a glimpse in the water of a white face or a moving limb and turns quickly away, refusing to help or to search for help (...) we all see the faces in the water. We smother our memory of them, even our belief in their reality, and become calm people of the world; we can never forget them nor help them. (131)

This passage captures the essence of the novel "faces in the water": there is an ethical responsibility towards the human beings trapped in the asylum, but it is unfulfilled. At the time of Istina's confinement, there was very little advocacy for patients and "recovery" was not yet a concept in popular consciousness: these ideas came later, around the time Frame was writing the novel. Here, Istina reflects on hopelessness and guilt. The water symbolizes a dream-like past, perhaps a metaphor for memory or collective consciousness, but it suggests a timeless

recurrence. The faces are forever drowning. In myth, water is inchoate and potential; it is where we all come from and where we all return. There is a sense of dissolving of self/other an eternal return to an archaic, preverbal world of silence. Individual identity is undifferentiated from the collective.

Brenda's encounter with her own face is intertwined with Istina's encounter with her guilt, which is heavy, silent and unmovable. Istina's guilt is triggered by listening to Brenda's inability to play the piano as she once did. In this guilt, Istina fears being submerged into oblivion along with Brenda. Sharon Todd in *Learning from the Other* believes that guilt can be a gesture towards taking responsibility for one's actions in creating an ethical and socially just world. Istina's guilt and silence could be read as an ethical possibility. As Lévinas puts it, thinking is an un-articulate "groping to which one does not even know how to give verbal form" (21). The relationship is silent and open. Thus, in order to meet the Other, one must believe in Infinity, which for Lévinas means a non-synthesizable ethical relation. Infinity from this standpoint is against totality, for it is not complete within itself but seeks endlessly to serve what is beyond itself. Infinity advocates for a togetherness of being face-to-face that does not collapse both faces into a unit but maintains the relation between the two. I see Infinity as silence, for it cannot contain a definable sound, it remains open towards endless possibilities. Yet we fear such boundless relations, we want to map out limits, delineate the expansion of the universe, function soundly within the laws of representation and being-in-the-world. Istina does not want to merge with the faces in the water, nor does she want to become like Brenda. This desire for separation and boundary is entirely understandable; it is bound to her survival instinct: "sometimes by a trick of circumstance or dream or a hostile neighbourhood of light we see our own face" (131).

“Seeing our own face” suggests revealing our unconscious bias through self-reflexivity. Unconscious bias refers to the automatic associations that our brains make about another individual based on an incomplete story. Learned stereotypes and essentialized notions of normalcy, as well as deeply rooted cultural, social and environmental factors all feed this incomplete story about the Other (Banaji and Greenwald). Uprooting unconscious biases is inherently unsettling, as Frame depicts. The differences that separate us, discursively, are usually seen as vertical instead of horizontal. Frame’s statement submerges us into relation with the Other and subverts the idea that we are separate from those we imprison in asylums. As we plunge deeper into the water of our unconscious bias, we learn how to engage with “the face”, how to listen beyond trying to know, and how to let go of the stories that keep us safely separate. Realizing she is trapped, a prisoner in her body estranged from her art and skill, Brenda becomes a stranger to herself, and the torture of remembering what she was once capable of but no longer able to do is too much to handle emotionally. She is full of rage and anger. The treatment robbed her of her sense of timing/time. Robbed of her artistic abilities and talents, she has nowhere to go but to destroy the piano, to rage against it, to assert what she has lost. Therefore, in the midst of playing, Brenda suddenly stops, “clearly struck by the irrevocability of her situation, and begins to rage and scream and thump violently upon the keys” (131). In this moment, she is then reprimanded for overreacting and told to never again play piano because “it always ends up like this” (131). What the nurses do not realize is that “it always ends up like this” because they always misinterpret Brenda’s anger as violence instead of as a cry for help. They do not listen to her pain as a legitimate form of distress, nor do they have the tools to care for her particular grievance.

Disciplinary responses to Brenda's reckoning with her own selfhood (her "face") deepen when we apply critical feminist lens. Women's anger is often pathologized as "psychotic". Even today, there are very few outlets for women's rage. Judy Chamberlin, a psychiatric survivor and activist from the 1980s-1990s, said at the National Alternatives Conference in 1994 that psychiatric therapies are often a form of social control because they try to resolve women's anger instead of attending to it as a "real expression of suffering" (ShrinkWrap 1994 audio recording). Women's anger, according to Chamberlin, is not "a symptom to be drugged, shocked or sterilized away" (ShrinkWrap 1994 audio recording). Thus, trying to resolve or cure is a form of silencing, especially if it damages the patients' ability to perform tasks and skills that were important to them. This kind of treatment is, according to Chamberlin, paternalistic and does not meaningfully engage with the intelligence, coherence and nuance of women's anger. Even if their anger is often an expression of trauma or abuse from their past, women do not necessarily need a psychiatric system to be involved in their recovery. Being angry and confident in that anger is a source of women's empowerment, and it should not be diminished by a system that calls it "abnormal behavior" or a "mood disorder," or, at the time of Frame's novel, "disobedience":

Anger is a source of our power (...) we will not allow anyone, psychiatrist or feminist therapist, try to convince us that we are sick because we are enraged, because we refuse to calm down and adjust to a reality that defines us as inferior. (Don Weitz Fond Box 25 ShrinkWrap 1994 audio recording)

Brenda's narrative background situates gendered psy discipline in social context. Upon a closer read, we come to understand Brenda was a victim of verbal and physical abuse from her brother. He was the one who signed papers to have her undergo the operation (130) which completely

debilitated her and ruined any possibility of exiting the hospital and having a successful music career. This was not an uncommon reality for a lot of the women found in the asylum against their consent. “Recovery” would mean she could be supported in playing piano, in continuing her relationship with music-making. But sadly, Brenda is another patient who was misdiagnosed—whose only reason for being incarcerated was because she was an intelligent, talented and out-spoken woman who is angry at the world for trying to limit her potential.

Compelled by the haunting “faces in the water”, Istina feels like it is her duty to protect others from harm. She feels responsible for their survival in the cruel and contradictory care of the asylum, and she wants to shield the other patients from the verbal abuse freely dispensed like medication. The nurses do not mind treating the patients like sub-human specimens; they do not see their existence or sovereignty. They believe them to be too braindead to understand the abuse. Madness cannot speak because the caregivers do not believe that those who are labelled mad can understand what they are saying, assuming they are too dumb to comprehend speech. Istina knows the patients. She listens to their stories, understands the logic of their incoherent, highly metaphorical speech, and compassionately listens when no one else will:

And it distressed me when the nurse, to excuse words that to an ordinary person would be hurting and cruel, said, ‘She doesn’t know any better. She doesn’t know what I am saying. Can’t you understand that these people to all intents and purposes are dead? (90)

The nurse’s rhetorical question: “Can’t you understand these people to all intents and purposes are dead?”, says more than she intends, revealing the asylum’s tacit agreement in the symbolic erasure of patients. They are known as ghosts before they are even dead. Dominant discursive practices are constantly repressing and erasing subjects from history through the attempt to

represent.. In *Specters of Marx*, Jacques Derrida explains how the ghost is produced by the incarnation of ideology, which is ingrained, incorporated and negated by the subject. The only way to overcome the haunting of ideology, or the construction of a fixed concept ingrained within the self, is to be open to it, to welcome its ghost as a way to think with traces beyond the trace. We need to learn to live with ghosts, to be unsettled and pushed along the borders of madness: “He should learn to live by learning not how to make conversation with the ghost—but how to talk with him/her, how to let them speak or how to give them back speech, even if it is oneself, even if they do not exist—even if they are no longer or not yet” (25). On the other hand, Jacques Derrida claims that we must be open to this kind of madness in ourselves, because reason alone is not enough to think with ghosts. Madness is thus a way to open ourselves up to the ghost: “There is someone mad enough to hope to unlock the possibility of such address” (14). Witnessing the ghost interpellates it and calls it into a speaking relation, which is often obscured by traditional forms of scholarship and knowledge production.

Janet Frame’s ethic of listening is compassionate towards ghosts of the living. However, though the novel portrays a grim asylum atmosphere, not all the nurses are without compassion. Those that once longed to care give up because of the inhumane management of the asylum. The nurses burn out due to long hours and understaffed wards. The working conditions are not sane or conducive for care, with no investment in recovery. Istina listens to the patients that everyone else has given up on—all the patients who have turned to ghosts, spectres of the asylum. Louise, a Holocaust survivor with intense traumatic flashbacks, has paranoid thoughts about her intestines. “Miles and miles of intestines” (93), she repeats incessantly. To get her to stop, to quiet her anxiety, the hospital staff gives her a lobotomy:

I did not talk to Louise; I listened to her. I guess that Louise was living a horror story more alarming than any found in science-fiction paperbacks. I felt sorry for Louise; she had a story to tell and they were disinclined to listen to her. (93-94)

After the lobotomy, Istina notices that Louise has lost her beautiful dark curly hair, once a part of her identity, a distinguishing characteristic. Istina recounts, “After her operation Louise became more docile” (94). The affective scope of communication is thus silenced, the psychiatric patient is restrained, and the treatment is given almost as punishment. The patient as a “person” is forgotten and erased from the equation; their body is emptied of all emotion, will, and soul. Frame is searching for the human in the mechanistic world of the asylum, through the sonic panopticon, she finds “the face” of the Other and welcomes its full alterity into existence as a meaning-making subject.

Madness as a “New Kind of Music”

Faces in the Water, rather than objectifying the Mad, can be read as describing the pathos of madness through the figurative language of music and sound. As Frame describes, madness becomes a “new kind of music” (77), with rhythm and harmony not generally understood by traditional composition or medicine. Of course, Frame’s words are always metaphors for something else: they do not directly describe their object, and yet they suggest a sense of what madness is. Istina begins to reclaim her voice within madness by embracing its musicality and song. The harmony of the institution relied heavily on the regulation of gendered sounds and voices (MacKinnon 101), and this form of regulation is evident in the “Season of Peril” sections of the novel (where Brenda is told to play ‘happy’ music on the piano). When madness becomes

a new kind of music, Frame is subverting what is considered “appropriate music” or “music as medicine” that asylums adopted to control a patient's emotional and gendered embodiment.

The music metaphors that Frame uses to describe the language of madness arrive late in the novel, once Istina has become one of the “permanent citizens” and has “settled” into the asylum. Frame builds upon Shoshanna Felman’s figuration of madness as an ambivalent meeting place of reason and irrationality, where the two polarities interact and activate an ability to witness incompleteness in a text (50). For Frame, madness creates a new reasoning system, a sort of body knowledge or phenomenological way of knowing. Attending to the rhythms of madness is attending to one’s emotions in the most honest way possible, a way of inserting the body into thought/rationality. In Frame’s reclaiming of madness, long before it was fashionable to do so, she heals the body/mind divide to allow madness to speak:

I belonged now to the ranging mass of people and the dead lying, like rests in the music, upon the ground. I knew the mad language which created with words, without using reason, has a new shape of reason; as the blind fashion from touch an effective shape of the sight denied them. (91)

Most of the patients that Frame describes in the novel do not have a voice that is taken seriously or engaged. They must sing the songs they are told to sing as a performative cure or musical restraint (Frame 91). However, the patients sing as a subversive tactic, which disturbs the asylum constraints and silencing forces. Singing can serve as a way for the patients to break free from the limitations of incarceration and to regain hope of freedom. Song empowers their vibrational power to exist, while making the asylum staff uncomfortable and resistant:

They sang with a gusto which seemed to disturb the minister standing soberly and self-consciously before his lectern (...)

They sang fervently (...) The men's voices prolonged and powerful if sometimes out of tune, often showed unwillingness to abandon a satisfying last note, keeping the sympathetic organist. (91)

Music is depicted as mnemonically generative and emancipatory for patients in the ward, triggering both communal and personal memory of a time when they were free. Frame positions music and sound as a way to reclaim a sense of self, community and home for patients in the ward. Istina's memory of her mother's songs helps her get through the day, helps her remember that she is part of a community.

I remember the idyllic songs my mother use to compose about this northern harbor that she had never seen...And the sight of the mud flats made me homesick for all the times I had stood on beaches when the tide was out and the shadows of the clouds moved across the Herringbone patterns on the sand, and I dug with my toes for clams and cockles. (90-91)

The asylum soundscapes, the peril and noise, are soothed by re-membering sounds and songs from home. Her re-membering of soothing sounds, that symbolize a time when she was free and cared for, highlights how sound is medicine for coping with trauma. This sonic healing and deep listening is described as the ethical healing process of *Dadirri*, an Aboriginal (Maori) listening practice that is a deeply contemplative process tied to remembering one's community traditions and quiet awareness towards new forms of wisdom (Atkinson 15)¹⁴.

⁹ Judy Atkinson in *Trauma Trails: Recreating Songlines* describes *Dadirri* as emerging from the work of Miriam Rose Ungumerr as "the 'Aboriginal gift' it has a special quality, a unique gift of the Aboriginal people. It is inner deep listening and quiet still awareness something like a contemplation the principles and functions of *dadirri* are: a knowledge of community; ways of relating and acting within community, a non-intrusive observation, or quiet watching a deep listening with more than the ears. It's a way of life, a way to heal" (15-16).

The life writing of madness betrays its silence, romantic fiction, its sublime unworldliness, Frame's writing provides an opportunity to listen to madness as a new kind of music instead of as a cacophonous stereotype. Madness is a literary device used to insert passion and outpouring into a contained rational form and have the body spill into an artistic realm dominated by the mind. The literary creation of madness, a trope for genius and forward-thinking or for great liberty and emancipation of spirit, falls short in the asylum, where it is unglamorous and fear-inducing. Frame characterizes the spectacle of madness as a loss of the inability to speak and be heard as an existential being. The negative capability of madness, the side that is not considered genius, and is seldom represented because it is too close to real-life, would ruin our popular notions of madness as "romanticized genius" (Frame 96). Bringing madness back to real-life makes it something we can relate to, it bridges the gap between us/them and conjures the possibility of our proximity to those we deem "insane" (96). As Frame mentions in her autobiography, *An Angel at my Table*, madness is a sensory and sonic vessel for engaging the poetic of our everyday phenomenology:

there is a side of madness which is seldom mentioned in fiction because it would damage the romantic popular idea of the insane as a person whose speech appeals as immediately poetic; but it is seldom the easy Opheliana recited like pages of a seed catalogue or the outpourings of Crazy Janes who provide, in fiction, an outlet for poetic abandon. (Frame, *Angel at My Table* 96)

None of the patients Frame describes could be the heroines of a novel. They are too crude, too much of a nuisance; and in engaging with her writing of them, in listening to their stories, I learn about compassionate listening beyond wanting to understand, but instead as a gesture of love. Thus, representing madness becomes a tricky endeavour. Such dynamics are caused by a

narcissistic hope to find a secret message about ourselves in the image; as readers, perhaps we hope to discover a hidden aspect of our inner self. Frame reminds us that “madness as a new kind of music” creates opportunity for listening otherwise and subverting the status quo. Madness can speak as music, as an emotional composition that brings listeners closer to their own existence. Despite how difficult it might be to witness madness and listen to its discordant rhythm, beneath all the layers of psychological explanations and pathologies that might defend against its expression is a kernel of truth that speaks of universal needs. These are needs we all have as existential beings: to be loved, to be safe, to be recognized by another, yet these are needs that psychiatry finds difficult to address because they are nuanced and subjective. The psychiatry of Frame’s generation is portrayed as a cold, unloving, and violent practice, where “It was forgotten that (patients) possessed a prized humanity which needed care and love, that a tiny poetic essence could be distilled from their overflowing squalid truth” (96). Listening to madness as music reminds Istina that patients have passions, desires and dreams. They want to sing, dance, move and create. This is when spring arrives, a time of hope and rebirth: a time of singing birds to end the “Season of Peril” and perpetual winter. Her engagement with the new kind of music helps her turn toward compassion. She ends the chapter with a scene from King Lear wandering on the moor, linking this to the men of the ward who are lost and have no home to return to: “I’m listening to their humming and moaning tingle through the air (...) listening to the cry of the drover as he called his dogs and listening to the distant sound of the sea” (113).

“Listening to the distant sound of the sea” reminds me that listening is a forgotten art and, in order to remember it, one must surrender to the vastness of the Universe to a sense of knowing that cannot be explained using reason. Listening allows us to transcend the limitation of 3D perception to be immersed in the imaginary and invisible worlds where parallel realities exist.

We can inhabit a different reality in listening, and this plurality loosens the discipline of music's hegemonic language and creates new dimensions within its sonic landscape. As Salome Voegelin writes:

(listening) allows us to challenge the status quo of certain political ideologies and paradigms of power (like patriarchy and white supremacy) it allows us to challenge the singularity of the real and articulate difference to show us how else things can be. (Voegelin 35)

This process is not generating the truth of an actual reality, but rather inventing the possible. Listening to madness as a new kind of music allows us to discover the world that was there before us knowing it. The affective immersion might seem daunting at first, or even overwhelming, because it forces us to question the "real" and "stable" ideas we have held as true, and instead settle for a more fluid interpretation. Much like Merleau-Ponty's take on phenomenology, perceptions are mutable and probable rather than real: "but what is not opinion, what each perception even if false verifies, is the willingness of each experience to the same world, their equal power..." (Merleau-Ponty 25). For Merleau-Ponty, possibilities are not real possibilities but possibilities of the *perception* of the real world of which they are but opinions. Perception, according to him, is the first text (Merleau-Ponty 24) in need of interpretation. Thus, adding madness to music suggests a shift in what counts as music: it requires interpretation that welcomes what cannot be named or understood using conventions of harmony. It requires us to welcome the unknown and the uncanny into our rhythmic consciousness and to listen to madness in a completely new way.

In alignment with madness as a new type of music, sections of *Faces in the Water* flow from structured symphonies to found soundscapes, as the narrative bends time and space into

dichotomous rhythm. This new kind of music is a “curse or cry” because the asylum, often composed as a monument of silence, is where patients are orchestrated, surveilled and silenced in a disciplinary fashion. However, Frame’s attention to this “new kind of music” is what elevates the voices we rarely hear, rising out of impoverished silence to a level of auditory power, amplified through her sound metaphors and imagery. Her inward sun sings for those who have no means of being heard.

CHAPTER 4: *Sounding Madness: My sound art in response to Faces in the Water*

In this chapter, I describe the sound pieces that I made in response to my dissertation research and close reading of Frame's *Faces in the Water*. I focus on what I have learned from Janet Frame about listening to engage with the history of ECT and women's memory erasure from a humanistic, ethical and affective perspective. I will discuss the components of the three sound art pieces and their methodology, which include "real-world music", "soundscapes", "sound collage," as well as "madness as methodology". I also employ theoretical concepts such as "listening otherwise" (Levinas, Lispari, Voegelin, Todd) and "madness as a new kind of music" to guide my compositional methods. Through my analysis of the process of making the sound art pieces that respond to themes in *Faces in Water*, I discover how listening otherwise is central to meaningfully incorporating phenomenological approaches to psychiatric listening that could potentially hold space for madness to speak. My work builds upon Voegelin's "sound as a verb" and MacKinnon's archival analysis of asylum soundscapes, but adding the voices and sounds from the psychiatric survivor and mad movement. "Madness as a new kind of music" is not about using music as medicine: it is about creating harmonic spaces for madness to express itself outside of medical pathologization, treatment or governance. I want to restore madness as a viable language, mode of expression and way of knowing. In the title of this dissertation I use the concept of "sounding" to gesture at the epistemological opportunities that sound can offer madness, how it becomes a vehicle for expression that transcends the boundaries of mind/body allowing for "practical wisdom" (Henrique 10) to resonate in knowledge-production. As Julian Henriques elucidates in his book *Sonic Bodies* about the subversive power of sound, he defines sounding as:

Sounding also has a critical edge against the text, discourse and the formalist and structuralist preoccupations of much recent work in the arts and humanities that the philosophy of light has underpinned. While these in their time have proved useful against positivism and behaviouralism such reductionism no longer occupies the position it once did. (12)

My engagement with sound and text is a way for me to express madness as a new kind of music and to liberate it from the discursive restraints of psychiatric language and empirical research methods. I weave Frame's voice within my larger historical context dating back to Victorian medical electricity, the industrialization of the ear and the gendered regulation of women's voices inside/outside the asylum. In my work of *Sounding Madness*, there is a double-hearing process where I listen to my voice inside Frame's and form an embodied witnessing of ECT survivor testimonies, accounts and experiences of erasure. Through using madness as methodology, I move beyond sanist and sight-centric epistemologies. Frame's voice as a mad writer and my voice as a mad interdisciplinary artist vibrate in different frequencies with the same call to action.

After reading *Faces in the Water*, I felt an urge to go out and record soundscapes that would correspond to what I was hearing while I read the novel. While Frame's writing is highly visual, my experience of reading her prose was distinctly audible. I also wanted to layer my own experience of loss and erasure with that of empowerment, advocacy and the strength which I had learned through working with the psychiatric survivor and mad movement.

All of these soundscapes have been fused using sound collage to create both a somber and uplifting atmosphere: one that engages with contemplative whispers of memory and the megaphone rage of protest. I play with the literal and abstract, the natural and built, as well as the

sound and unsound. The sound pieces are presented in three parts and engage with the themes of the text: “Faces in the Water”, “The Season of Peril” and “Madness as a New Kind of Music”.

The sound pieces are meant to trouble the “listening subject” as someone who has the security of understanding. Traditionally, within a diagnostic paradigm, the one who listens is the one who diagnoses or prescribes. As MacKinnon says, “the western psychiatric model determined the visual and sonic boundaries of madness” (79). In my work, I want the “listening subject” to question what the subject hears more deeply, beyond the desire to know with scientific certainty. The experience of “memory erasure” is sonically represented through various motifs in Frame’s novel (as mentioned in Chapter three) as well as the subversive qualities of “madness as a new kind of music” (Frame 77). Themes such as alienation, confinement, disorientation, sonic panopticon and existential loss of meaning are juxtaposed with listening otherwise and sound as a verb. Through collage techniques, a non-linear version of the novel is presented to illustrate how the past can be repeated in the present, radically, to the point of dislocating it, to the point of making one forget the origin of the event, thereby making the past malleable in the present and future. The goal is to find ways to listen beyond comprehension, out of an ethical turn towards uncertainty, and the possibilities that such madness opens up. In my sound art, we hear the unseen. Roland Barthes describes listening as a form of de-coding. Listening, for Barthes, is an attitude beyond a physical capability that reveals what is obscure, blurred or mute in order to make available to consciousness the “underside” of meaning (*The Responsibility of Forms* 252). “Evenly hovering attention” (Barthes, *The Responsibility of Forms*, 252) is how he imagines the ideal listening relation, which requires patience and an ability to creatively engage with what is being said beneath the sounds of language. I am also seeking to engage with phenomenological listening to trouble diagnostic listening. This perspective posits

that there is no longer an objective “real” outside of its subjective meaning. The “real” is no longer merely there; it represents something for the subject. Meaning is produced by previous experiences.

The sound pieces embody the theories of listening outlined in my dissertation, especially the ones engaged by Janet Frame in her novel *Faces in the Water*. One of the major features of the piece is how it captures the many rallies and protests that I have attended, where I have had opportunities to record various real-world soundscapes of psychiatric-survivor and Mad voices. Intersections between Mad studies/survivor epistemology and sound studies emerge to critique the biomedical psychiatric paradigm and regimes of truth. The ways in which ECT survivors have used their voices to speak out and resist the institutions that have invalidated their experiences embody the principles of “sound as a verb” (Voegelin 17). Taking up what Katherine Norman describes as “real-world” music where “candid recordings of everyday life” function to reflect on experience and place the composer and listener in an imaginative dialogic space, I listen, not to the composed sound in itself, but to the chaotic process that gives the sound an ethical relation and responsibility towards an unknowable Other. My sound art pieces are collages of everyday sounds, interruptions, and protests that break up a classical score: they lend a *sensitive ear* to a difficult composition.

I collaborated with musicians who self-identify as mad/psychiatric survivors (like myself) to create a soundscape that would take up Frame’s concept of “madness as a new kind of music”. I conceptualize “new”, in this context, as a re-remembering of ancient traditions that considered sound to be a re-balancing modality for the body: where everything is in a state of vibration, everything is frequency. For example, sound was used as a diagnostic tool in ancient Egypt and continued long into the Middle Ages (MacKinnon 93). Harmonics were understood as a display

of universal principles of balance: as above so below (MacKinnon 93). In Frame's case, "madness as a new kind of music" reclaims pre-linguistic sound, the vibrational witness of experience, and advocates for listening otherwise, beyond certainty and knowing. I hope to engage with sensory perception as a quantum phenomenon, to highlight how our brains are not computers or filing machines, but rather elegant universes. With greater connectivity through senses, we can access transgenerational memory where time and space collapse into continuums of patterned intelligence.

The ear is at home in the depth and textures and timbre, recognizing the complexities of melody, harmony and octave transposition most readily. This is not to essentialize the sensory modalities but to recognize their affordances (Henriques 10). My work is also grounded in the legacy of mad movement organizing as a subversive voice that speaks truth to power, and I want to distance it from "art therapy" or "healing". My work is an intervention into conversations about ethics, voice and memory for ECT survivors who do not subscribe to the "recovery narrative" (Woods, Hart and Spandler) and an inquiry into how we could possibly listen otherwise, instead of only qualifying their testimony as storytelling for the sake of healing. I weave Frame's voice within a larger historical context, dating as far back as Victorian medical electricity (a precursor to modern ECT) and the rise of the industrialization of the ear. Women's bodies have been put on display, literally and figuratively, within a genealogy of psychiatric recovery narratives centered on submitting and submerging one's voice and madness to the greater good of "erasure as cure". As MacKinnon explains:

[T]he harmony of the institution relied upon the gendered regulation of both the asylum landscape and soundscape. The perceived medicinal and moral capabilities of appropriate music and sounds to restore not only the physical but

also the mental wellbeing of women explains its constant use as a medical and moral device for social governance. (101)

My project enacts layers of power, from electricity to sonic vibrations, within a wider panopticon of systemic and institutional power. I explore the power of voice, physically and symbolically, to destabilize the smooth acceptance of psy-epistemology as the dominant interpretation of madness. As such, my work seeks to rebalance knowledge-production beyond hierarchies of sensory experience and categorization, as Henrique describes sonic epistemologies that “turn away from the hierarchy of the senses and the dominance of vision in particular towards a pattern of cooperation of sensory modalities in which each contributes its unique qualities for our negotiation through the ambient energy flux” (Henrique 10). I enable a distinct and different way of thinking expressed through sounding, one that welcomes madness as valued knowledge and critique.

Turning experience into a coherent story is inherent to the technologies of recovery, but at what cost? Janet Frame’s novel is not a coherent narrative; it is highly ambivalent, as I discussed in Chapter three. It predates the possibility of recovery. My work returns to listen and engages with madness. To come at recovery from a slanted position, a nebulous and ambivalent stance. Sound is not something we can see, hold or touch—but we know it is there through listening. It resists definitive understanding to welcome an experience.

Therefore, my sound pieces are not all necessarily about ECT or music as a treatment, or about whether or not ECT works. They are about whose voices are listened to within knowledge-production and whose get erased. My work is about the experience of re-membering one’s erasure and trying to come to terms with what that might mean. In the future, I hope to create an immersive art installation, not to fabricate empathy but to stir critique, discomfort and

uncertainty. I want to create an uncanny and embodied witnessing of testimonies, accounts and experiences of erasure. My recording process and my reading of *Faces in the Water* comes alive against the backdrop of “brain stimulation” and “recovery narratives” produced by institutional discourses. For example, in a 2016 *Atlantic* article entitled “The Ethics of Erasing Bad Memories,” ECT’s memory erasure is not challenged; it is embraced. “ECT is now surprisingly modernized, currently used in mainstream medical treatments for schizophrenia, mania and catatonia. Most radically, ECT is now being used to alter and destroy memories. It is framed as a new miracle treatment that must be salvaged from stigma because it can save lives” (23). This contemporary text mobilizes the same discursive formation common in the late 1930s and 1940s, positioning ECT as a miracle treatment that gives hope as it quiets people (especially “hysterical women”). In response, my work asks: how can the grain of Janet Frame’s voice be re-covered, excavated, historicized and incorporated into current ECT medical discursive practices and knowledge-production that silences mad epistemology and critique?

Frame’s writing in *Faces in the Water* introduces sound as an important means of knowing madness beyond the confines of silence or the incoherence of noise: it is a meaningful expression. My goal in using sound to lift Frame’s story off the page is to promote listening otherwise to madness as a new kind of music and to interrupt the false harmony of psychiatric institutional recovery narratives. This is an ethical form of listening to madness, one that is not solely designed to diagnose but to hold space for all that cannot be understood with reason.

Sound Collage and Madness as Methodology

Since I do not seek to produce conclusions or theories of certainty, my process employs art-based and “lived experience” methods, including narrative inquiry, auto/ethnography, collage, archives, and “madness as methodology,” to both deepen and open up theories of listening beyond diagnostics. My dissertation thus emerged out of a creative analytic practice where I sought to develop new ways of producing analysis that are mad and subvert certainty and rationality. By using sound collage in addition to traditional methods of analysis, I hope to capture what cannot be said or written, but to listen to a language beyond words and images. I do not seek to produce a representation of ECT’s “memory erasure” as documented in Frame’s writing, but rather to engage with it sonically and subversively. I hope to open up the possibilities of ethical communication that are non-linear and indirect. In order to do such research, I need to use artistic and mad methods. As Carolyn Ellis writes in *The ethnographic I*, artistic research enables transformative inquiry:

Artistic research speaks of a continuous, self-reflexive and recursive movement, questioning the situation and determining a position with regard to the configuration of space and analysis. (Ellis 177)

To capture the narrative nuances in my sound recordings that jump through time/space, I also use a mode of inquiry specific to sound called “conduction” that corresponds to madness as methodology. In his methodological essay “How to be Influenced”, Micheal Jarret writes about the railroad’s influence on music and electronic culture as “conduction.” Conduction “jumps the tracks of logic” and helps inquiry act as a conduit for reasoning from thing to thing that replicates and mutates relations. Kodwo Eshun writes about how conduction happens when “overlapping patterns of rhythms interlock (...) then effortless sensation pushes you along”

(Eshun 45), which relates to the process of madness as methodology and collage. Jumping the tracks of logic in his book *Madness as Methodology*, Ken Gale emphasizes how inquiry and research methods need to embrace a non-linear approach to fully grasp the layers of experience that are not immediately understandable through traditional observational scientific methods:

Engage in context not in a linear, developmental manner, page by page, but rather in an indeterminate and free-spirited way driven by experimental inquiries and impulsive curiosities, moving from one plateau to another. (2)

This kind of embodied methodology is not a didactic exposition, but a subtle way of writing as an experiment, not in a traditional academic way (thesis + evidence + analysis = conclusion) but rather as an emerging dialogic process that channels ancestral knowledge the kind of knowledge that has not been written down but that haunts, and is known through the experience and movement of writing as creative inquiry, as a way to end up somewhere you never thought you would go, or that such a place even existed. Madness as methodology is a way of life, a way of knowing and a way of ethical making-meaning. The ethics involved in madness as methodology is one that accepts responsibility for what cannot be understood with conventional scientific methods and requires a fearless leap of faith into the unknown. I welcome this leap because it allows my artistic process to be fluid and emergent instead of rigid and formulaic.

The conception of sound collage emerged during the early modernist era and continues today, as sound artists are using similar theories to explore unsaid traces and the uneasy sounds of history. Keeping this uneasy relation in mind, when Andre Breton, the father of Surrealism, claimed that the incessant murmur of the unconscious could not be recorded through automatic writing but through the audiotape, he set a precedent for artists to write sounds differently. This is a practice that sound artist and theorist Salome Voegelin is particularly interested in. She

investigates how sound is written about, and how the act of listening is recorded through her writing, which she calls “textual phonography.” As such, she records her process of listening which “produces another sound. The sound in the imagination of the reader is not the sound heard but the sound generated in her action of perception of reading about sound” (Voegelin 25). As much as writing is a soundscape composition (Frame), writing is also a form of listening that speaks. This collaged interface between writing sound and recording sound is at play in my work as well. Sound collage creates a context for communication to exceed a need for comprehension or certainty, enabling a relationship (one that does not fit into the limits of language) to exist *otherwise*. In the 1950s, William S. Burroughs demonstrated this concept by reconfiguring audiotape and writing across its metallic particles to insert language into sound with shock (Kahn 15). By writing language onto sound, instead of letting sound convey linguistic meaning, Burroughs utilized principles of collage (displacing objects from familiar contexts and making them fit into a new strange space to create a new frame of reference). Such techniques have been revived in sound art, “where the epistemological process of interconnectivity is indeterminate and resistant to synergy” (Garoian 92).

Collage, when defined as an art practice, is the act of gluing together. It is a method of taking pieces from a former self and putting them back together in a new way. Collage is, in fact, a “recovery”: a way to salvage and reuse. Perhaps, from this standpoint, collage is a radical way of coping with loss. This gesture is similar to “radical hope,” as defined by Jonathan Lear, the epistemological task of creating new fields of possibility when one’s concept for understanding what is possible has collapsed (89). Collage also aligns nicely with principles of sounding, as it requires the integration of complex dynamics and contradictions that resist dichotomies:

Sounding in a complex set of relationships is invariably expressed on several different registers at the same time. Most often these registers are considered separately, isolated from each other, as with mechanical and social process, or technological or psychological levels of analysis. The conceptual force of sounding is to refuse such dichotomies. (Henrique 4)

The conceptual synergy between sounding and collage helped my artistic process to be one that was grounded in an embodied and emergent practice, instead of a hypothetical or purely analytical exercise.

This counter-method is not so much about establishing a systematic method as it is about breaking methodology open in “an attempt to show what it can do” (Gale 2). Madness as method is that energizing force that drives deviance, delire and digression. It encourages incessant flow and flourishing that brings new life to practices of world making that is full of surprises and always offers new challenges. By combining "madness as method" with “sound as a verb,” I hope to move beyond merely discussing representation, instead making the structures underpinning them come alive to bear witness and take responsibility. I do not pretend that I will solve medical violence or psychiatric epistemic dominance, but I can suggest ways of listening otherwise to uproot unconscious bias and centuries of authority, even if just for an instant:

We already live in permanent states of transition, hybridization and nomadic mobility in emancipated, post-feminist, multi-ethnic societies with high degrees of technological mediation which, however, have not ensured justice for all, or resolved enduring patterns of inequities. These are neither simple nor linear events, but rather multi-layered and internally contradictory social phenomena. They combine elements of ultra-modernity with splinters of neo-archaism: high

tech advances and neo-primitivism which defy the logic of the excluded middle.

We therefore need great methodological creativity to cope with these challenges.

(Gale 15)

My project is not so much about *reclaiming* madness, but recuperating and creating within it. I take up a double-hearing of sound where it is both a physical vibration with frequencies audible to the human ear and the notion of “being sound.” Madness as a method is an energizing force that drives deviance, delire and digression. It encourages incessant flow and flourishing that brings new life to practices of world making that is full of surprises and always offers new challenges. As a result, I hope to disrupt the rational/irrational divide embedded in romanticized notions of madness working through what Michel Foucault describes as the historical moment that made us forget how to be guided by what we might know as madness (75) and the silences between. The immersive nature of listening is what I am trying to recreate in this first piece of “faces in the water”. I create an intimate space to the invisible yet always/already present. Underwater, the truth is said in a submerged, unconscious way. What comes to the surface in distortion? A face that reminds you of your response-ability. A voice that calls you to attention, intrigued and full of unanswered questions. The voice of the silent drowning face in Frame’s novel is interdimensional, flowing through different generations. As I read Frame’s words, I am reminded of the voices that are obscured in the medical and psychiatric journal articles that revive the promise of ECT without listening to the “grain of the voice” in survivor literature like Frame’s. My project seeks to think about ways that we can listen to voices we find difficult, disruptive or challenging, whether these voices seem to come from inside or outside ourselves. I ask how I might create a compassionate inter-listening experience of memory erasure and

women ECT-survivors who have not been given space to be heard either within society or health care institutions.

Unsound Sound

What we call sound is an onrushing, cresting, and withdrawing wave of air molecules that begins with the movement of any object, however large or small, and it ripples out in all directions. In *The World is Sound*, Joachim-Ernst Berendt builds a theory that the very possibility of consciousness depends on sound. Applying interdisciplinary theories of musicology, philosophy, psychology and spirituality, Berendt reveals that the universe is measured in harmonic processes: at the root of all physical reality, there is music and rhythm, a play of patterned frequencies. He writes, “Our eyes only scan surfaces. Our ears, however, immerse themselves deeply into the spheres they investigate by hearing” (7). Berendt goes on to note how once we learn how to hear again and engage in forms of deep listening, we will be more aligned with ethical possibilities that honor the planet in a balanced and sustainable way.

Similarly, in psychoanalysis, Guy Rosalato and Didier Anzieu foreground sound as an essential part of subjectivity: through the “sonorous envelope” and the “acoustic mirror” of the maternal voice (Rosalato and Anzieu qtd. in Schwarz 25). Sound allows the human subject to remember pre-linguistic meaning, to re-enter an auditory comfort zone, a “womb-like sonorous space that envelops the subject and allows it to shape itself against an exterior” (Rosalto and Anzieu qtd. in Schwarz 34). Returning to this state of pre-Oedipal consciousness creates space for endless imagination and possibility, where there is no hardened form or meaning. Music (or organized sound), according to David Schwarz in “Listening Subjects: Semiotics, Psychoanalysis,” can remind us of developmental processes when we crossed from imaginary to

symbolic experiences that “the musical representation is a sort of threshold crossing and produces listening subjects” (Schwarz 34). In many ways, sound’s presence/absence creates subjectivity: “We are born in and of sound, before ears we hear through the skin” (Pettman 1). Sound, unlike vision, is an inescapable primordial sense that transcends normative sensory ability, as Dominic Pettman elaborates:

Vibrations are the interface between the experience of an ear that functions as designed and one that does not, since no one not even the profoundly deaf can escape the sonic feeling of sound waves. (2)

Western culture is dominated by the less intimate and more critical eye. But in fact, the ears witness more than the eyes, as Pettman explains: We “cannot close our ears” (2); they are always open. Even without ears, we can always feel sonic waves with our skin. Sound penetrates our bodies entirely, and it is what captures our embodied knowledge. Pettman maps out the sonic geometry of early psychoanalytic relations, how the infant comes to know themselves through sound prior to the Lacanian mirror stage (3). This precursory knowledge is essential to listening otherwise—as a way to return to our pre-linguistic sonic selves. The undifferentiated soup of sensory experience, where we merely exist with our surroundings, as one, is where we can begin to listen otherwise (Pettman 4). In listening, our infant self vocalizes: “We are sonic creatures, but historically we have difficulty recognizing that fact” (Pettman 4). The dominance of the less intimate and more critical ocular sense reigns over knowledge production and has for centuries. Western medicine’s “medical gaze” is positioned as the objective mechanism to “know” the patient. As I discussed in previous chapters, the medical gaze is central to the foundational epistemologies that govern scientific and psychiatric praxis. Listening, from a medical perspective, is a tool to *see*.

I am interested in the “listening subject,” particularly how it is formed within psychiatry as a diagnostic tool immersed in objective reality, compared to Frame’s notion of listening, which liberates the listening subject to embrace madness as a “new kind of music” or a remembering of ancient wisdom. Listening otherwise is a way to engage with madness as subversive subjectivity. I take up Frame’s idea that “madness is a new kind of music” that might change how we listen to those we do not understand and form different kinds of subjectivities. How can we let go of understanding as the goal and let listening hold space for the unknown and the possible? The ephemeral and dynamic character of sound makes it a great tool to disrupt the stability of knowledge and it can help us navigate the world of the unseen, yet felt. Sonic embodiment is a way of knowing that Henrique describes as “our own subjectivity that needs to be recognized and appreciated rather than sacrificed on the altar of object science” (4). The embodied knowledge that sound provides us with can help us develop listening skills to welcome madness as epistemology and valued insight. Thinking through sound is a way to unlock a subversive wisdom to help us dismantle systems of power as Henrique elaborates upon:

Sound is always a dynamic event, forever incomplete and continually in a state of change. Thus thinking through sound offers a way to voice criticisms of the status quo and raise questions, in the way that images are often used to settle them. In the mechanics of auditory propagation noise is necessarily a disturbance, it disrupts and can be used as a destructive weapon. (Henrique 5)

The disruptive energy of sound is a source of political power, when thinking through the audio archives that I was immersed in during my research, the voices of psychiatric survivors and mad activists emphasized similar themes as the characters in Frame’s novel, and through my sound art I sought to reconfigure their resonance with each other.

The inherent assumptions within language that “to hear” is to “be sane” is one that I hope to deconstruct with Janet Frame’s concept of “madness as a new kind of music” and “listening otherwise (Ackerman 175). These linguistic positions intrinsically link hearing with logic, with being able to think and reason with clarity; hence the phrase being of “sound mind” (Ackerman 175). Listening beyond needing to know with certainty means we are listening with our entire bodies, our embodied memories and transgenerational senses. We are no longer listening in a linear or structured way that expects a resolution to the story. Madness resists a unified coherence, and it resists homogenous meaning. It remains open-ended. Moreover, these links between hearing and sanity fail to understand how the body does not just hear with its ears; we hear with our skin through vibrations. In this sense, sound is powerful in crossing epistemological boundaries, “since no one, not even the profoundly deaf can escape the sonic feeling of sound waves” (Pettman 2). Sound calls us to attention, allowing us to be transformed, to submit to its power. Sound is weightless, invisible, carried in wavelengths: it travels through time and space with great subtlety, effect and possibility. It conjures both intimacy and distance.

Sounding is a way for practical wisdom to resound in knowledge-production. To trouble empirical evidence and traditional scientific research methods, sounding is a process not an object or a representation, it transcends thought towards feeling:

This intrinsic meaning of sounding is often independent of conscious attention, as with prosody of the actual utterance, that is, tone of voice. Thus the idea of sounding serves to draw attention to a rather different object of enquiry than the conventional ones of text or image. In practice it is not object at all, but a process or event, not coded representation but medium, not thought but feeling. (Henrique 2)

By reframing what counts as evidence and how that evidence is gathered, sound and sounding can be a creative intervention into knowledge production. Sounding inspired me to disrupt the psy industrial complex and the recovery narrative economy that promote an un-nuanced version of patient experience as always/already aligned with clinical goals, diluted, depoliticized and distanced from activist voices (psychiatric survivor movement or mad movement). This storytelling economy, based solely in the medical models idea of recovery, creates what I call a false harmony that suppresses and erases other ways of sounding one's truth.

Notions of "purity" continue to be assigned to research methods that distance the researcher from the research. Research operates in the context of "evidence-based" medicine where the roots of evidence are fundamentally flawed. This has resulted in an emphasis on technical expertise and the use of individualistic frameworks which not only obscure people's social-material world in our understanding of people's experiences, behaviours and distress: it also marginalizes the lived experience and knowledge of those deemed "mad" or "mentally ill." Clinical trials remain the highest form of investigation within mainstream health care, yet many studies have proven their pharmaceutical promotional bias and reliance on a faulty diagnostic framework that generalizes experience in ways that are not helpful to the individual seeking help. As I mentioned in Chapter Two, psychiatry is a science that deals with perception and attempts to understand it based on a scale of "normalcy" that is flawed at best, as it often pays mere lip service to the social determinants of health. Diagnostic forms of listening, focused on finding a genetic or biological basis to mental illness, often contradict the complexities of experiences by people who are experiencing madness or altered states of consciousness. As Faulkner writes, "In reality, few people fall easily into one diagnostic category without complicating features, symptoms and secondary or amended diagnosis" (Faulkner 503). Randomized clinical trials

(RCTs) are the most difficult to validate because it is almost “impossible to identify people with the exact same diagnosis, findings cannot be generalized beyond the trial and treatment outcomes cannot be effectively measured” (Faulkner 503).

Frame’s voice as a mad writer and my voice as an interdisciplinary mad artist vibrate with different frequencies, yet they resound with the same call to action: breaking the Truth of empirical science and history in half. To be clear, my sound pieces are not *post-truth* but *polyvocal truth*. These narratives permit us to call into question the conclusiveness of ECT narratives produced by psychiatric hegemonies of knowledge-production. They provoke an encounter with memory traces and voices that do not fit nicely into a “master narrative” or trope of miracle treatment or cure. Both the voices captured by Frame and the soundscapes she describes challenge normative historical and contemporary psychiatric ECT practice. My sound art presents a limit-case that cannot be solved but must be attended to. Frame reclaims her voice through representing voicelessness. By writing soundscapes of madness cannot speak and madness as a new kind of music, she calls attention to sound, to being heard, but more importantly to *listening* as a transgressive act. Her autobiography is a work of memory against erasure, against the cure of silence. Those who are hearing voices in her novel are never hearing their own, yet Frame offers a way in to listen towards possibility.

Sounding madness is a way to listen otherwise; it is a way to question the scientific imperative within psychiatry and to offer different modalities for welcoming testimonies and speech that do not conform to sanist standards of knowledge-production.

Piece 1: Faces in the Water

The first sound art piece deals with concepts of self-reflexivity within psychiatric listening and asks what psychiatric listening can learn from sound-art. In keeping with the title *Faces in the Water*, this piece will include a pool of water with a broken mirror at the bottom that audience members will gaze into. Their gesture of gazing will trigger a motion sensor that will play the sound piece on surrounding speakers. The piece is comprised of underwater soundscape recordings of a lake in the middle of February (I recorded in North Bay 2014). The recordings have sounds of ice breaking and the sounds of footsteps walking through snow: sounds which are featured prominently in the novel when the narrator, Istina, reflects on the persistence of winter. My soundwalk recordings focus on listening to the natural environment and to the human voice. This sound piece aims to expose our ears to sounds that we rarely pay attention to, just like the voices of those who were trapped and drowning in social stigma throughout Frame's *Faces in the Water*. In addition, I recorded my voice reading passages of the novel. Bringing it to life, conjuring Istina's voice as it spoke to my own lived experience of the psychiatric system, I was hoping to reflect on how Istina's voice resonates within my own and within generations of women who have undergone non-consensual ECT and have claimed "memory erasure". Istina's voice is a reflection of Frame's voice and a reflection of my voice reflecting upon the voices of others. The act of recording defies and subverts erasure, yet the process remains unfinished and full of incomplete meaning: it requires an audience to engage with it and to reflect upon it. Such reflexive and inter-subjective techniques have been integrated into sound art practices where the "epistemological process in which interconnectivity is indeterminate and resistant to synergy" (Garoian 92). Such resistant interconnectivity has led to what Katharine Norman describes as "reflective listening" (35): a type of listening that imagines content within the gaps or silences,

not to make sense of sound, but rather to re-think one's relationship to sound. She says that: "listening is entirely up to us" which shifts the composition process from a bidirectional transmission towards a participatory design that emerges as the listener participates in a self-reflexive way. Even as listeners, whether consciously or unconsciously, insist upon making meaning out of disjointed and fragmented sounds, the point is not whether the narrative makes sense in a linear way, but whether it resonates and moves the listener towards something new; a new way of thinking and feeling about an old concept.

This first piece "Faces in the Water" is also where sound breaks the "mirror stage" of psychoanalytic conditioning, reminding us that we are always/already in the aural phase of potentiality before sight and language. A womb like sensation that is open and vulnerable. In this state, we receive, we listen intimately. This is a form of "inter-listening" (Lispari 159) an all-encompassing envelope of "interaction, interdependency, interrelation, intersubjectivity, as well as an acknowledgement of the attunement, attentiveness and alterity always/already nested in our processes of communication" (159). The ethical potential in attuning one's listening reflexively to an unknowable Other beyond the veil of linear meaning, means that one can let go of didactic understanding. This attunement is an opportunity and offering, not a directive. It is meant to play with the idea of listening as a way of seeing oneself in the mirror of relation. Listening is an orientation towards the Other—an orientation of "attention and giving to others" (Lipari 197). Listening expresses vulnerability and the "enactment of responsibility" of welcoming the Other by creating a dwelling space to receive their alterity and to let it resonate (Lipari 198).

This is meant to provoke uneasiness and frustration to some extent, but also to overwhelm meaning with polyvocal possibilities. As Pettman says, "the aural streams in which our pliable sensorium are nurtured, having been unwrenched from the all encompassing

heartbeat that pulsed through our first nine months...the voice of the other-the other whose attention we desire remains a highly charged and intangible object” (Pettman 26). I want to recreate this womb-like intimacy as a dwelling space, but to make it strange and uncanny. The voice of the Other that calls us to attention is not necessarily an easy encounter, but rather, it is a haunting sensation. In Frame’s words, describing the sensation of listening to Brenda in the ward who attempts to play piano after receiving ECT, it is an uneasy experience in responsibility:

Listening to her, one experiences a deep uneasiness as if having avoided an urgent responsibility, like someone who walking at night along the banks stream, catches a glimpse in the water of a white face or a moving limb and turns quickly away, refusing to help or search for help. (...) We all see the faces in the water. We smother our memory of them, even our belief in their reality and become calm people of the world; we can neither forget nor help them. (...) Sometimes by a trick of circumstance or dream or a hostile neighbourhood of light we see our own face. (131)

In Chapter Three, I describe the significance of this scene for which the book is named after; as the encounter with the Other who is trapped between worlds, whose voice is drowned out and erased from history. This moment of hauntological encounter triggers a sense of urgency to remember and to speak out against those who have submerged the face and voice of the Other. Frame’s description of this weighted reflection is something I wanted to portray in my sound piece. I wanted to have my voice as a reflection off the water of imagination. Merely listening to diagnose or understand, as often happens in the medical field, forgets the ethical possibilities of listening beyond knowing. Lipari says that listening “must entail a deep sense of welcome for the Other that affirms their coming is in accord with the welcomers’ will” (198).

Sound breaks the false mirrors, the false selves and the power of those “subpersonality” voices in our consciousness: the internal critic, the anxious worrying, the perfectionist etc. It destabilizes the weight of these false narratives, of the stories and voices that harden us instead of opening us up towards infinity (Levinas). After all, “the voice is very far ahead from the face” (Deleuze and Guattari). We come to realize that we are not alone, but bound to a deep cellular and aural connection to all that exists and transcends time. The time of memory sounding in waves that are in perpetual motion, locating the divisions of past, present and future is impossible. They are all ebbing and flowing into one another, the composition of our subjectivity is thus never without ancestral reflection:

everything has already been lived and relived a thousand times by those who have disappeared but whom we carry in the very fibers of our being just as we also carry in the thousands of beings who will live after us. The only question which incessantly poses itself is why all of these innumerable particles floating in each of us, certain ones come to the surface rather than others. (Scott 238)

In this piece, I explore what comes to surface: anxiety, fear, uncertainty and guilt. My voice speaking Istina’s voice, is holding onto layers of feeling that cannot speak truth to power in a linear or direct way. Sharon Todd in *Learning from the Other* talks about the ethical potential of seemingly negative emotions like guilt, that awaken a sense of urgency within the individual to enact change. Todd stresses the importance of listening to “that which is not easy” (131). I consider how listening otherwise requires an ability to attend to what may seem silent or absent. From this stance, ethical communication is not solely based on the content of what is said but as Levinas puts it “the nearness and orientation we bring to the Other” (130). This piece tries to engage with the silence that speaks and uses gaps in the recording strategically. Advocating for

silence, Susan Sontag describes it as a practice that keeps things open, thereby never ceasing to imply sound in silence (11). By creating a context to receive the Other in alterity as infinitely unknowable, I attempt to demonstrate a form of listening that attends to the rupture of meaning and that “says more than what is being said” (Todd 121). Building upon Frame’s narrative, my dissertation and sound art considers how the act of listening to devastated sites (both internal/external) recognizes “place as witness.” Listening to “place as witness” means that one must give up knowing the truth as a totality; instead it creates a context for asking more questions and opening up the site to new ways of engaging ethically with trauma.

The goal of this piece is to highlight how we might be able to hear ourselves in the Other and to recognize our responsibility towards them.

Piece 2: Season of Peril

The second sound piece illustrates the “mad movement” of psychiatric survival, through a “Season of Peril” and vocalizing that experience politically to incite system change. I use sound archives of city panel discussions led by psychiatric survivors, as well as soundscape field recordings of protests that I participated in over the course of the last decade. I imagine the installation piece will include shadows moving throughout the room to the rhythm of voices. This will create a hauntological effect, how the values and principles of the past echo in the present towards the future: a re-membering of the shadow and spirit of psychiatric survivor protests. This piece is a heavy collage of multiple jarring sonic elements. There are four sections to this sound collage: city hall, radio show, psychic reading and protest. The major question that I ask in this piece is whether sound collage can recover memories under erasure? As Bachelard says: “Our construction makes us reconsider this world of silence (76).

My sonic construction is made up of incongruent polyvocal soundscapes that span decades of historical contexts and events. Parts of my life are woven into the wind and into protest. The piece opens with a wind storm collaged over Bonnie Burstow's voice discussing the "perils" of ECT in a 1983 Toronto city panel. She opens with saying "no memory whatsoever of anything that happened prior to her shock treatment (...) an entire past wiped out" her voice is meshed over rhythmic humming that flows with the wind. There is a storm going on in the metaphorical background that mirrors so much of Frame's literary soundscapes. Wind is an important sound for Frame especially in the "Season of Peril" section of the novel where she says: "and it was always our Season of Peril: electricity the peril of wind sings to the wires on a grey day" (11). Her electric wind song is full of fear and worry about what she might lose. She is worried about losing her memory and voice as a writer. According to Schafer our "human voice" is merely borrowed from the wind: "we could not express ourselves vocally without the wind we first inhale from the atmosphere" (Pettman 70 qtd. Schafer). Much like Frame's emphasis on the vox mundi in her novel, the "Season of Peril" is where Istina reclaims her voice through the voice of nature: the only way to escape the horrors of the "Season of Peril" is to be heard. Soundscape is a way of listening to the world. The collective voice. The testimonial voice. The gendered voice.

Coming into political consciousness and into the public sphere. No longer intimate, it is public and it is amplified through a megaphone and microphone.

Frame's literary soundscapes are the key to unlock a deeper critique of persistent and powerful discourses operant within the psy medical industrial complex that privilege certain voices and ways of being over others, to deconstruct and denaturalize the authority of medical epistemologies and voices. In this sense, her literary soundscapes enact the social and political value of listening otherwise to madness that cannot speak. They are silent, and in my piece,

“Season of Peril,” I bring them in conversation with the soundscapes that surrounded my involvement in the Mad Pride movement in Toronto.

Soundscape is traditionally understood as the auditory version of the landscape¹⁵ (Schafer). A soundscape contains keynote sounds which distinguish an environment and background ambient sound (Schafer). Unlike acoustics, this approach deals with the transfer of information rather than energy and considers what sound means to the individual (Schafer). For example, the emotional response to a soundscape shows how a person feels towards that environment. The approach has been used within urban environments by asking how the perception of sound can be used to improve the experience and build a richer picture of the individual’s response to space:

[S]oundscape composition is located within a continuum of possibilities, each with its own practice of mapping or representing the world (...) the evolving nature of the listeners’ relationship to acoustic space can be compared to developments in soundscape composition. (Schafer 1)

My soundscape composition is taking the “real-world” music that Katherine Norman describes and blends it with Salome Voegelin’s “sound as a verb” (17). I am not interested in the semantic debates over what constitutes a soundscape, or how the term should not exist at all (Tim Ingold). The point is that the sounds are related to the world, found in the world and distort that world when we listen. Salome Voegelin’s essay “The Ethics of Listening” discusses how, in some

¹⁰ Tim Ingold’s critique of soundscape in “Against Soundscape” posits that sound should be the auditory equivalent of light instead of being understood as the equivalent of sight (leading to concepts such as soundscape). He claims that the concept soundscape is incoherent. By his logic, distinguishing soundscape from landscape is false because the “environment that we experience, know and move around in is not sliced up along the lines of the sensory pathway by which we enter into it. The world we perceive is the same world, whatever path we take, and each of us perceives it as an undivided centre of activity and awareness.” For Ingold, a landscape could be audible and thus these semantic divisions are inaccurate, and even damaging from a phenomenological perspective.

cultures, sound is a material object: sound is as material as stones and aids in the construction of meaningful space. Thus, the ontological characteristics of sound depend on culture. One of the limitations to ethnographic research on cultural meanings of soundscape is that anthropologists cannot presume to know what people are hearing. The ear and what is physically heard does not constitute the auditory realm that people perceive or occupy within their imaginations. Voegelin subverts Tim Ingold's argument in "Against Soundscapes" by framing soundscape as a positionality within the ethical possibility of listening. She says that Ingold's framing of soundscape as a "medium" is inaccurate: soundscapes are a reality and materiality. They participate in the construction of reality. As Voegelin says:

Ingold suggests that the landscape is only visible once we have rendered it visible by techniques such as painting and photography. The landscape can only be audible when played back within an environment that deprives us of stimuli, such as a darkened room. (Voegelin 11)

Voegelin studies soundscape "not to transport us elsewhere but to understand the here and now"(11). She is interested in the relationship between the soundscape and the landscape instead of arguing over the semantic power of one over the other. This relationship is ethical in nature and serves to understand mutable and plural worlds that lurk beneath the surface of our perceived reality. This is a new kind of semantic inhabiting, a temporal and reciprocal bind that "actualizes the world", but not through categorical definition or truth, rather it is through sublime doubt or uncertainty that one comes into "being". The "mysterious unfolding of things of which I do not know what they are" is how Voegelin articulates the ethical power that listening can have on epistemology and phenomenology. How do we know what we know, if not through an encounter with the Unknown? She moves from soundscape to sound world. Voegelin wants to understand

the lifeworld of the soundscape as an alternative world that we visit and come back from with a heightened awareness:

The unseen worlds of the soundscape produced by this listening mapping stand not as opposed to the reality of the soundscape but pluralizes its conception and thus they need to be taken into account in the construction of its actuality.

(Voegelin 48)

My response is to apply gentle methods on hard issues, centering listening otherwise as an ethical gesture and the role of soundscapes in rethinking how we listen to mad people, beyond market-based priorities and biomedical cures towards rebuilding peoples' quality of life and resilience. Soundscapes can help engage in difficult histories, to re-member, to work-through and to locate listening as central to micro and macro forms of recovery outside of neoliberal constraints and power. Listening becomes a way to care for memories. In my soundscape, the voices of ECT are also spliced with everyday soundscapes taken from Parkdale streets, near the psychiatric hospital where ECT is administered, to bring the idealities of revitalization back to reality, back to real world sounds. There is a sonic patterning in my work between the personal/the political, the natural/the built. In this pattern, within the noise pollution and chaos of Parkdale's gentrification/redevelopment process, I weave concepts of madness cannot speak (Foucault, *History of Madness* xxviii) with "sonic nuance cannot be heard" (Voegelin 48) to grapple with the limit case of memory erasure. The voices of individuals stand out amongst crowds of protesters, the thunder and rain crash against the sounds of jackhammers breaking ground and electric saws cutting beams. Gospel voices resound in the wake of a funeral and behind it a woman's voice sings: "Dreaming I Was Always Dreaming". This layering of

soundscapes asks how I might listen to memory as if it were a heartbeat that speaks in emotional landscapes.

The significance of recording ECT protests in Parkdale is key. Parkdale is where the Mad Pride movement began; where madness was reclaimed as a site of power, as a voice, as a new way of communicating beyond linear concepts and the fiction of sanity. Holding a placard that reads: “Memory is Sacred”, in 2009 I attend a rally in Parkdale entitled “Stop Shocking Our Mothers and Grandmothers”. I record the rally. I listen to the voices of other survivors who took to the street, who marched to City Hall, who organized rallies and panel discussions, who would not be silenced until the city heard them. Many were advocating for housing and poverty reduction, as well as for improvements in the social determinants of health. Listening to radical activist and psychotherapist Dr. Bonnie Burstow speak from her megaphone, boldly stating: “ECT destroys what is essentially human”, it makes me wonder about the ethics of erasure and what it means existentially. Thinking back to the “Memory is Sacred” placard, relegating “memory” to the sacred makes it untouchable, restricted, and therefore unproductive for the work of mourning. Freud taught us that the work of mourning, much like memory, requires it to be shareable, and uttered in testimony. If the roots of autobiographical fiction are in severing, shocking and forgetting past traditions, how can this genre become a form of ethical recovery in contemporary life writing by psychiatric survivors? Thus, a non-linear version of the story is presented to illustrate how the past can be repeated in the present, radically, to the point of dislocating it, to the point of making one forget the origin of the event, thereby making the past malleable in the present and future (re-memberable). The goal is to find ways to listen beyond comprehension—but rather out of an ethical turn towards uncertainty, and the possibilities that such madness opens-up.

On first thought, electroconvulsive therapy and Parkdale's gentrification may not seem to have anything in common. They both deal with entirely different landscapes: the brain and the neighbourhood. However, a closer look reveals how they share a metaphorical link: the promise to erase and revitalize. Parkdale is the site where the metaphorical link between these two processes comes to life. On one hand, it is the site of experimental urban planning in the name of slum clearance, and on the other it is home to the psychiatric hospital where ECT is performed and where ex-patients, from the asylum era, currently live in boarding homes. The rhetoric of "bad memories" functions just like "bad neighbourhoods" in that it serves to justify their erasure. As Janet Frame wrote in *Faces in the Water*: "my personality was condemned like a slum dwelling" (86). Frame's metaphor of her personality being like a slum illustrates how psychiatry's mechanisms for assessment lean in a similar direction as a city planner evaluating the value of property: neither is listening in a dialogic fashion; they engage to diagnose flaws. They espouse getting rid of painful memories like bulldozing eyesore buildings or by evicting those who reduce the property value. Listening to the city as if it were a person who has survived a traumatic past, a past that needs to be attended to, heard and believed today, in the present tense, is a way that I have navigated and engaged with the irony of using extreme measures (ex. electroshock or eviction) to help someone in distress. What does it mean to recover from mental health crisis or trauma, when recovery is centered on deletion? Recovery, thus, becomes a sophisticated form of repression or a new way of covering over a persistent wound. With "memory erasure" (Andre 6), the person is no longer an active-participant in their recovery process, becoming a passive, voiceless observer. Evelyn Scogin recounts in her post-ECT memoir *Descent*: "this type of loss is much more and not simply because a memory is gone. It's as if that entire time frame never existed. Something more fundamental is lost because it involves

not only whole periods of time but also erases all feelings and sensations, all connections of anyone or anything. For me it felt and continues to feel as if I never existed for that period-of-time.” (132). Memory erasure in this iteration is immensely destructive; it takes away the tools that people use to construct or reconstruct their subjectivity.

“How does one speak from a place of erasure?” was the central question that I struggled to answer in my work with ECT survivors’ memoirs. They all told their life stories from the limit-case of not knowing who they once were, or feeling like a stranger to themselves, but they also spoke from a place of agency and resistance. I was namely working with women who did not consent to ECT, but had been coerced into accepting the treatment as a last resort. Before creating the soundscape piece of ECT survivors/Mad Pride activists living in Parkdale under the pressures of gentrification, I thought of doing a documentary style piece, where I would interview people who had ECT and ask about their experiences of memory loss or erasure. After speaking to my aunt about her experience with ECT, I realized that a linear oral history could not encompass the nuance between forgetting, memory-loss and what Linda Andre defines as, “memory erasure”. There is an ethical implication for considering how one narrates a life re-routed by shock. As such, I could not simply interview people; I needed to be immersed in their soundscapes for their voices to resonate beyond loss and erasure—for my listening to change. There was so much information in the sounds around them, in the places they lived; I wanted to be surrounded by those sounds. To listen to context. R Murray Schafer, a Canadian composer who introduced the concept of “the soundscape” to music theory, argued that one could discern the social conditions or the wellness of a place by accessing the quality of sound. The soundness of place and being, for Schafer, were interconnected. This led me to think; why not engage with the acoustic environment where madness could speak on its own terms at the edge of erasure?

In a similar vein, Dr. Mindy Thompson Fullilove, a public health psychiatrist from New York studied the impact of urban renewal projects and their erasure and displacement of mainly poor Black communities from city maps. Her term “root shock” refers to the psychology of place and the traumatic collective loss that “slum clearance” has on individuals. She argues that this form of memory erasure is collective in nature, and causes pain that cannot be pigeonholed into a diagnostic category but rather it must be understood as a communicative expression about endurance in the face of bitter defeat. Likewise, my soundscape engages with stories of suffering from song, to funeral procession, to the rage of protesters in a thunderstorm, to city panel discussions—there is collective grief in Parkdale that resounds in every aspect of life.

When Foucault talks about how madness cannot speak, he means madness cannot be understood or listened to beyond the need to categorize its speech into illnesses in need of cures. Recently, medical journalists have made the claim that ECT is coming back, newly revamped, as a “miracle cure” for severe treatment resistant cases of depression and PTSD, able to free people from the prison of their “bad memories”. From 2013 to 2016, *Time Magazine*, *Nature* and the *Atlantic* all ran articles about the same ground-breaking study by Marjin Kroes, from Radboud University in the Netherlands, confirming ECT’s ability to “erase bad memories”. In these articles, electroconvulsive therapy is framed as a cure for post-traumatic-stress disorder, claiming that it “successfully impaired reconsolidation of episodic memories (...) that is to say, memories were partially and in some cases almost entirely erased (Delistraty). The emerging possibility of deleting “bad” memories demands us to ask: what exactly are bad memories? To qualify something as “bad”, suggests it is deviant, unwanted and undesirable. There is not much arguing with the moral and punitive rhetoric surrounding the term “bad”. Trauma, on the other hand, is more nuanced, it is a wound that does not heal but remains for life, like a scar. How one wears it,

and learns to live with it, depends on a lot of factors beyond the brain. Memories construct and reconstruct traumatic events, but are they necessarily “bad”? Dr. Arthur Caplan, an ECT advocate, believes so when he says: “bad memories can make us prisoners to ourselves”, denoting that these memories will aggressively inhibit our lives, constrict our movement and destroy our freedom. Invoking the metaphor of imprisonment, Caplan is not listening to the countless testimonies of ECT-survivors who have said the contrary; how ECT did not delete the right memories and left them feeling disoriented and confused. As recorded in my soundscape, Dr. Bonnie Burstow, says: “An entire past is wiped out. We make sense of our present and we make plans for our future in terms of our past. When the past is taken, the person cannot function as a meaning-making human being” (PSAT Don Weitz Fond “Shock Treatment City Forum, 1983 audio recording).

That new way of listening otherwise might be through “sound as a verb”. Voegelin, building upon Heidegger’s work, defines sound as a verb that “sounds” reality and makes the listener aware of how what they “hear” may not be what is “sounded” (17). She says: “sound is the thing thinking, a contingent materiality that is not captured as a noun but runs as a verb” (17). Thus, listening can transcend the fixture of representational “Truth”—this listening does not recognize; it listens not for what a sound represents, but hears what it might generate. The ethics of listening, thus, is a contingent negotiation that requires participation and imagination. As she describes: “Listening makes all possibilities actual as generative actualities: generative truth that produce their own reality” (Voegelin 83). Listening not as mastery or “understanding”, and not as a finite process—but as an opening, an uncertainty. This kind of listening would challenge curative goals, and attachments to objectivity—towards generative processes of engagement.

Working with soundscapes of the Mad Pride movement both present and past, I center listening to silence, or what has been silenced through dominant representations, as an ethical turn necessary for history to become praxis for re-authoring towards justice in the living present. What I hope to accomplish in my soundscape was a method in listening otherwise, beyond the diagnostic dyad or patient/doctor or developer/resident, would be to hold space for the unknowable and attend to what has been uprooted and erased through violent disruptive processes. The fluidity of listening otherwise affords a communicative exchange that resists hermeneutic dominance, or as Schafer puts it “sound imperialism” (91). Listening, in this sense, makes possible ethical engagements with marginalized individuals who are silenced within the confines of biomedical institutions and language—it becomes a way to encourage their speech to resound in meaningful ways toward building narrative community outside of psychiatric labels and patient management.

Piece 3: Madness as a new kind of music

I watched from the special table, as from a seat in a concert hall, the raging mass of people performing their violent orchestration of unreason that seemed like a new kind of music of curse and cry with the undertones of silence flowing through the quiet ones, the curled-up, immovable and nameless; and the movement was a ballet, and the choreography was Insanity; and the whole room seemed like a microfilm of atoms in prison dress revolving and voyaging, if that were possible, in search of their lost nucleus. (77)

The third piece “madness as a new kind of music” takes up the above quote from Frame’s novel and puts it into compositional practice. This piece reflects on power, voice and memory, much

like the other pieces, but in a more chaotic and symbolic way. I worked with two mad musicians to create an electrical soundscape that would bring to life the sonic metaphors in the novel: namely the ones where Istina is witnessing a surge in power in the patients around her, and how she stays “safe” by hiding and listening from a linen closet (26). Sound as intimate power and sound as social power collide in this piece, which is a sort of accumulation of the two previous pieces I discussed: “Faces in the Water” and “Season of Peril”. “Madness as a New Kind of Music” creates a context for sound as a verb to subvert the epistemological underpinnings of madness cannot speak. I hope it can bring listeners closer to the symbolic abyss, to confront their fear and misunderstanding of madness. But more than that, I hope to create a context for questioning power on multiple layers, from the electrical, sonic, subjective and social. Bringing to life a section of the novel where patients subvert the institutional power of the asylum through their bodies and voices in a new kind of music that speaks of transcendence and freedom, I want to showcase how these actions are productive and important for navigating this history of memory erasure.

We used a range of experimental methods to make this piece. Firstly, all of the vocals were recorded using blindfolds to allow us to let go and fully immerse ourselves in the experience of the song. We were also trying to symbolize the emotional blindfoldedness experienced in the psychiatric ward, how painful it is to be facing deep emotions without the ability to express them or be received by others. One musician said how they always felt emotionally blindfolded trying to find a way through unrecognizable feelings. We wanted to release all imprint and memory of our experiences with psychiatry and just flow with our immediate unbridled senses. The voices in this piece are severe and intense. They are difficult to listen to. This discomfort was intentional since we wanted to recreate the feelings that were

present in Frame's writing: fear, uncertainty, disorientation, hopelessness. In a way, we were trying to confront the abyss of madness, of going to the other side, where we were no longer sure who we were, and what was real. We wanted to create a sonic embodiment of madness. We tapped on the microphones to create a heartbeat, and to conjure a sense of haunting. We used major intervals to create a distorted sense of "happiness" to gesture to psychiatric treatments that promise miracle cures but only provide an artificial chemically induced uplift. This piece begins with disorientation and transitions to an expansive opening. There is a pause, where one might think the song is over, but it moves to a more tranquil and hopeful sound. I equate this transition to a sun rise after a long dark night. The noise dies down and the sky parts with light shining through. This transition is important, we were trying to symbolize how things have to get better. After surviving so much trauma and isolation we have to survive a new day, we reclaim our voices through sound.

In this piece, we created a sonic world where listeners can welcome shock subversively through sound, not as a "new way of quieting people" (Frame 9) or a form of erasure, but as an opportunity to find a new "nucleus" of power from which to speak, listen and move differently. Outside of the imperatives of rational meaning, the voice that we hear in the piece is submerged, distorted yet powerful and strategic. It is the nucleus that Frame is talking about in the scene I quoted earlier: "and the whole room seemed like a microfilm of atoms in prison dress revolving and voyaging, if that were possible, in search of their lost nucleus" (77). This creates an uncanny disorientation, similar to the feelings we have while reading Frame's narrative. It requires us to listen in a different way beyond an orderly or predictable rationality, towards a collective sense of madness as unsynthesizable knowledge. I trouble the "listening subject" in this piece by narrating Frame's narrator, from a distance. Unlike the shock of ECT that is a new way of quieting people, this kind of shock is chaotic yet uplifting, it is meant to encourage movement. It

shifts how we listen. It is not to understand but to join the dance and to let go. This “new music” is shocking and unsettling, it welcomes the audience into an abyss of chaotic sounds that end up swallowing my voice or “the listening subject”. The illusion of a composed subject is an illusion that keeps us sane, it keeps us from entering the chaotic dance of meaning-making from a place of erasure. The patients that Istina describes are disoriented, lost, confined and alienated from the social world. They cannot speak, yet they make music and dance. The shock of witnessing and listening to such a scene is what I was hoping to create with these abstract electronic sounds. These are unsound sounds and they intersect with Mad Pride rhetoric to move beyond voice, towards gesture and movement. Frame’s writing uncouples language from reason and ventures freely into sound as it is experienced rather than described. As such, this sound piece mimics this sentiment and transports listeners into a different dimension of the “real”. Beyond a documentation of real-life music found in sonic ethnography, this new kind of music isn't really music in a harmonic sense, but rather in a performative sense. It gestures towards the liberation of sanity’s illusions, to free the subject from sanist language and thought.

Unlike the “Season of Peril” sound piece, the sounds in this piece are musically produced using guitars, keyboards, microphones and sound editing software. I read the relevant passage from the novel that outlines the theme while the musicians created a soundscape around my voice like a body of water. There are no environmental or organic soundscapes in this piece. The reason for this is that I wanted to create a new kind of world, one that sounds almost post-human.

I am hoping that it can create a context for audience members to listen in a way that questions the “real” and “stable” narratives we have of being in the world. Music is a language which communicates embodied experience. We listen with our bodies to its language. Madness speaks in this piece through the absence of a coherent and linear composition centered on harmony. Instead, it is a jarring, jagged and haunted piece. The use of echoes and distant screaming highlight this feeling. The central emotion is one of frustrated expression: “like pure emotions music surges and sighs, rampages or grows quiet and in that sense it behaves so much like our emotions that it so often seems to symbolize them, to communicate them and to free us from the elaborate inaccuracies of words” (Ackerman 206).

As seen in the novel, the scene where Istina notices the patients’ revolt with music in the asylum cafeteria, this frustrated expression is finally released at the end of the piece. The droning voice that is interrupted with static holds the electrical violence of ECT. It is meant to symbolize how the voice changes under its frequency. This voice is difficult to listen to because it is damaged by distortion and it hides in cavernous tones. This suggests that madness cannot speak in repressive environments. It highlights what remains hidden or repressed through ideology and epistemic violence. Muffled and confused, it emerges to be listened to otherwise. We are required to understand the relationship between listening and speaking differently: “locating responsibility not only on those who are marginalized but also on the conventions and institutional practices that determine who and what can be heard” (Baylosis 3).

As a new kind of music, madness lands elsewhere in this piece. It arrives in an expansive open field. One that is elevated with higher tones and brighter sounds. No longer weighted by social constraints. It is sonically liberated, and ends on a hopeful note. I imagine this piece would be staged in a completely different way than the other two pieces. I am not sure if I would want to

include objects in the installation or simply have a dark room that gradually becomes brighter as the sound piece comes to an end. This is still in development.

My focus on experimental form and research-creation is intended to challenge master-narratives that shape grammar and gait. I am grappling with what cannot be said, represented, remembered or heard. My emphasis on the energetics of experience breaks the traditional music score and the false harmony of psychiatric listening protocols. By channeling spirits of dissent (Frame, psychiatric survivors and mad activists/artists) hauntologically, I bring the past/future into conversation in the present.

CONCLUSION: *Future Possibilities for Sounding Madness and Listening Otherwise*

“Poetry isn’t revolution but a way of knowing why it must come.” (Rich 224)

Adrienne Rich sums up why art, in all forms, matters in helping us create a livable future for all, especially those who are not understood, welcomed or cared for in socio-economic and political landscapes of austerity that are built on strategic exclusion. My project employed “sound as a verb” (Voegelin 17) for voicing the limitations of care within the psychiatric industrial complex and for legitimizing the trauma that has been named “groundless” (Fink 17) by ECT supporters and clinical administrators who have excluded the testimonies of survivors from their analysis. My work is grounded in the emancipatory potential of listening and collaborations with historical and contemporary survivor testimony. Janet Frame is the only author in the ECT-canon to prioritize sound as a literary device. As I read her autobiographical novel *Faces in the Water* and her life writing trilogy *An Angel at my Table*, I wanted to transform her writing into a score to sound “madness as a new kind of music” (77) to find the “lost nucleus,” the most sonorous syllable, of the survivor/mad movement. My intentions were to attempt reparation for the epistemic violence of erasure through listening otherwise (Levians, Lispari, Voegelin, Todd).

My dissertation and sound art do not advocate for art as therapy but rather as a disruption of an epistemological hegemony. Thinking-through how madness might speak moving forward, my conclusion reflects upon current states of psychiatric listening, through engagement and through contemporary ECT practices reflected in “recovery narratives” deployed by institutions. These are coerced “recovery narratives” much different than the coercion we encounter in *Faces in the Water*. These narratives remain staged and controlled by the psychiatric industrial complex to promote a particular kind of recovery; one that reflects neoliberal values of being a productive member of society who is calm, self-sufficient, engaged and responsible for managing their behavior and

emotions according to biomedical standards that define what it *means to be well*. The “journey” of recovery in these narratives is plotted with the intent to erase madness as a viable and livable state of being.

My sound art “madness as a new kind of music” welcomes the dissident, unsound, haunted voices of those who seek justice and reparation for the coercive pathologization of their anger, trauma and passion. Not only do I employ Frame’s powerful poetic and sonic language in breaking silence, I am trying to represent erasure in a way that doesn’t reduce it to spectacle or empty performance. I want people to think about how they are listening to the pieces I created, instead of the specific content (words, speech, voices, soundscapes, music). The way people listen matters as much as the sound art itself. Let’s rethink how silence can be an opportunity to bring the future into the present as a new kind of music that expresses what cannot be expressed in linear or rational language/thought. My work as a sound artist, poet, and academic is to attend to histories of erasure, those whose voices have been taken out of the story. I consider how to bring them back in. I am pushing for an engagement with history towards a livable future where we can listen, re-member and collaborate to create new social harmonies where people can express madness and be listened to without pathologization, prescription or coercive treatment. My goal has been to represent truths that have been left unsaid or what has been erased from history (noting how even in our best efforts to memorialize or remember in institutional settings/format it often falls short of creating real change).

This work manifests my historical, artistic and theoretical journey. Mapping the contradictory layers and history of ECT within early medical electricity and tracing the genealogies of shock in survivor texts was not something I expected to discover when I set out to study autobiographies of “memory erasure”. I wanted to listen to the voices of women who were

coerced into receiving a treatment that ultimately cost them their memory. I wanted to listen to Janet Frame. I wanted to listen to my aunt. I believed my aunt when she said, *they didn't erase the right memories* because I trusted her ability to express what happened to her in the ward, and what went wrong. I wanted to listen to generations of psychiatric survivor activism. To embrace madness as a new kind of music, I experimented with mad musicians to uncouple formal harmony from a fluid self-reflexive process of creation. I wanted to listen in a way that would allow madness to speak.

Listening is a bridge to another world, one where we care for our memories of erasure through the mad possibilities of sound. I am not suggesting that my work will ethically solve the problems that psychiatry has with listening to madness, as Salome Voegelin says: “listening will not automatically get us to a better world or even a better philosophy. Sound does not hold a superior ethical position” (Voegelin). But sound can show us the world in its invisibility: the unseen movements beneath its visual organization that allows us to see its mechanism its dynamic and structure and the investment of its agency which might be dark and forbidding. My analysis of Janet Frame’s life-writing and novel *Faces in the Water* illuminates how listening is an ethical gesture to welcome madness as a new kind of music. Frame’s writing is full of textual phonography, full of sound metaphors and moments of listening otherwise. Her sound poetics move her text into realms of perception that re-member (put it back together in a new way) an event, and re-open experience in ways that do not cover-over its emotional voice but, rather, attempt to utter its story of distress in other words. Through collaborating with Frame’s writing, I used sound to liberate listening practices away from diagnostic imperatives towards dialogic possibilities. Utilizing the recorder’s ability to amplify, superimpose, slow down and capture the

vibrations of poetic voice, I was able to rediscover the possibilities of the voice as a site of memory, imagination and music.

My sound art rethinks the place of listening within Mad Studies and psychiatry, to problematize the over-emphasis on voice/engagement and argue for an incorporation of listening otherwise into the fold of advocacy. For example, the “Season of Peril” sound piece was centered on generations of ECT survivor/Mad Pride voices, from past to present. Madness as a new kind of music de-centers voice as a knowable subject. As Cherry Baylous explains:

the emphasis on giving voice has coincided with many initiatives within the field of mental health that engage with C/S/X perspectives. Yet sadly, many initiatives that offer space only partially and selectively hear the narratives told by Mad people invited to speak. (2)

This theme of “giving voice” to patients is rampant in engagement scenarios run by mental health institutions as I have outlined in the postscript, but it is also a key feature in Frame’s writing where she questions the genuine intent of the doctors who make their rounds to meet patients and “listen” to their ideas or concerns. Ultimately, my project questions what happens to the Mad activist’s voice when it is engaged and listened to by the psychiatric industrial complex. As Jijian Voronka states in *Troubling Inclusion*, “these systems of power now incorporate such narratives not as critiques but as commodities to benefit organizational interests and solidify mental health truths” (Vokonka, *Troubling Inclusion* 33).

Frame’s work interrupts the smooth harmony of the contemporary ECT popular discursive practices deployed by psychiatry to convince us that erasure can be a cure for trauma. As best as I could, when composing the sound art pieces, I tried to align with Frame’s theory of listening otherwise while integrating the quotes from survivors and activists who have motivated

my work, to create a sort of hauntological soundscape of voices that transcend time/space. In doing so, I wanted to attend to the mainstream History of ECT that discredits and trivializes women's survivor narratives as "gothic horror" (Endler 64). This form of epistemic violence and humiliation is why Frame decided to veil her life writing within fiction, that way readers would receive her message and absorb it with an open mind. With fiction, her words could travel further, resound more deeply and be, ultimately, believed. Being believed is what Frame and her characters were seeking in *Faces in the Water*.

Studying the long history of medical electricity discourse, the ebbs and flows of its public reception and support, made me realize how little we know about consciousness, trauma and its complexity. I explore the contradictory relationship between Frame's development of "voice" and agency, her misdiagnosis of schizophrenia and how her creative process of listening and writing leads towards the compassionate integration of madness within selfhood. I call this process, in Frame's case as in the women who survived ECT's memory erasure and chose to represent it through fragmented autobiography, "re-membering erasure". Erasure is thus subverted from being a site of suffering and emptiness to being a site full of creative and radical potential for transformation.

Finally, once I delved deeper into the main concepts of *Faces in the Water*, which I identify as Time, Memory and Selfhood, I found that listening otherwise could open up a space for madness to speak. I elaborated how these themes in Frame's novel are woven in rich symbolic dynamics of natural rhythm and artificial mechanism (the sounds of nature combined with the sounds of the institution). Listening to one's inner landscape, as well as one's surrounding environment, is the compass that Frame uses to find meaning, direction and integration after the asylum years. Some of the key questions she symbolically engages within

the novel are: Does orchestrated “memory erasure” help us survive, or does it re-traumatize and disorient? Does memory fail because it must? Is erasure an experience of being lost in time/space, or is it the experience of being displaced without the necessary skills or knowledge to get home? How can the traumatic experiences of patients be attended to compassionately and meaningfully while confined within institutions? And finally, is erasure compassionate? Still, I do not have answers to these questions, but I hope to explore them further in my artistic practice and sound installations. Future iterations of my sound art and engagement will involve interactive and immersive listening to madness as a new kind of music.

My hope is that the psychiatry curriculum, pedagogy and practice could include and collaborate with madness liberation and listening otherwise. I hope that mad epistemologies and diverse interpretations of mental distress, not just engagement with patients as “experts”, can be used in a collaborative way to push the status quo towards meaningful change, for mad epistemology to be valued within psychiatric institutions. I long to see psychiatry embrace artistic modalities, not to encourage empathy, but to encourage reckoning with difficult histories, to encourage reparation for past harm and enact justice for psychiatric patients and survivors today. By changing how they conceptualize mental health recovery beyond the alleviation of symptoms, but towards a full articulation of one’s difference, agency, right to exist and speak as *mad*. How can psychiatry learn to listen otherwise? I wonder what that kind of “space” would do to genuinely transform the way psychiatry engages with mental suffering and distress in institutions.

The patient engagement enterprise was not created by patients and it is a form of false listening. As Jennifer Johannesen says, “it is unclear what the patient demands are” (2). The optics are always positive: they showcase the end of punitive and oppressive asylum era

practices but conceal how even when given a platform to speak, madness cannot speak because it is regulated and controlled. The ecosystem and landscape of “patient engagement” and psychiatric listening as a compassionate mechanism is one that serves to validate the institution, not to empower critique or change. Simultaneously, the “fantasy fold” (Hall 244) created by the “voice of lived experience” becomes an authentic fetish-object used in PR campaigns to justify psychiatric dominance. The ahistorical, uncritical, self-absorbed navel-gazing subject does not have anything to say but borrowed soundbites from the institution that manages its cadence. In this instance, there is no difference between Foucault’s madness cannot speak and the voice of lived experience as it is managed under the spectre of “patient engagement frameworks” that serve institutional agendas of “ethical domination” (Voronka). Yet experiential knowledge is important and should balance any empirical study.

“Listening” within the contemporary mental health system is diluted by clinical outcomes and the engagement enterprise because it is still held captive by the scientific paradigm that seeks to manage patients. Paradoxically, patient engagement is a form of silencing that looks like empowerment. Thus, even if the extreme form of silencing and memory erasure described in Frame’s experience seems outdated and impossible today, there is still an optics of sanitizing madness to the point of silence.

The embodied and sensory aspects of memory elucidate its importance for uncovering traumatic pasts and re-imagining possible futures beyond the constraints of scientific objectivity or the genre formalities of autobiography. My choice of form and focus on Janet Frame was to enact my analysis of her life writing through sounding and re-membering. I turn away from the hierarchy of the reductionist, empirical and objective research approach to disrupt how it settles ideas into conclusions. I legitimize what has been made invalid by institutional medical and

academic ecosystems to repair the epistemic violence of erasure. I want madness to be heard and to be loved. *Sounding Madness* is a request to create a receptive context for madness to exist, speak and reverberate as a valid way of knowing and perceiving the world. I re-member the voices of memory erasure and mad epistemology and ground them in our current mental health system. I honour mad epistemology as a power and electric current that is guiding towards what a justice-oriented future might look like, feel like and sound like.

POSTSCRIPT: *Critique as an Act of Love*

I want to share a quote that both haunts and motivates me, a quote that follows me inside and outside institutional spaces. It comes from a conversation I had a long time ago, while trying to understand this business we call “patient engagement” and I tried to figure out where listening came into play. I share this quote, partly because I find myself constantly thinking of the irreconcilable ethical issues it brings up, and my responsibility to listen dialogically, across generations of discrimination and activism, and attend, here, today to what it might possibly mean: to “engage”. With it, I hope to provoke different kinds of conversations about engagement. And perhaps to haunt and motivate others. “Critique is an act of love. But engagement is a process of neutralization, it strips the social and political critique from the activist’s voice” (conversation with colleague).

This quote simultaneously reignites and extinguishes my faith in the ethics of engagement. If engagement is to be ethical, it must be critical, it must risk undoing what it builds. It must doubt what it thinks it knows about others, those it seeks to engage, who are not always involved in defining its boundaries.

My understanding of “critique is an act of love” is that the attentiveness necessary for critique is the same that can be found in love. And when I say love, I am thinking of Luce Irigaray’s definition of love as a “respect for the other whom I will never become” (*I love to you* 77). This non-violent, non-possessive love allows for movement between difference, and allows for self-reflexive risks. It’s not about empathy, or feeling good about oneself. That’s when we create these fairytales of engagement that end happily ever after, that end on a neutral tone. So if engagement is a process of achieving neutrality, of sanitizing critical voices into a false harmony, then there is no ethical possibility within its processes.

Both love and critique can be unsettling, since both require us to unearth our assumptions, to reflect on our biases, to let go of what we think we know. Kathryn Church has said that engagement is not about representation, it is about entering an “unsettling relation” (*Forbidden Narratives* 73) that enables change and that allows us to make-meaning. We must be willing to harness this transformative potential to grow and learn despite how difficult and humbling it might be. But if engagement is a process of neutralization, of settling-in and being at ease with ourselves, then there is no room for critique, no room for change, and no room for love.

When thinking about the ethical possibilities of engagement within mainstream institutions, I am reminded of bell hooks’ reflection on language and what happens when we borrow language that isn’t ours, but to borrow nonetheless to be heard: “Often when the radical voice speaks about domination we are speaking to those who dominate. Their presence changes the direction and shape of our words” (hooks 28). I often think about how my words have changed since working within an institution. I think about the language of “passing”, the language of sanist professionalism that I have adopted in order to get into grad school, write a dissertation and fit into mainstream corporate settings. It’s a language of silence, of holding my tongue, of sanitizing my radicalism.

So, it’s important to distinguish that “engagement” branded and managed by institutions is not liberation, nor is it a substitute for social justice movements. Yet the language and discourse of contemporary engagement is full of social justice emancipatory language, allegory and allusion. Borrowed language to neutralize critique urging us to join this new “movement” without any accountability or commitment to the communities who have been speaking out about medical and institutional violence for decades. This branding needs to stop. I am

concerned about the co-optation, and subsequent depoliticising, of ideas and practices that emerged through survivor/Mad Pride liberation movements by psychiatry and formal psychiatric services who do “patient engagement”. Branding this form of engagement in “social change” rhetoric is not only philosophically problematic and unethical, it damages our potential to collectively mobilize for tangible, material change.

History is never linear, in many ways the struggles of the past that we thought we over and done with, are still with us today. Unless we seek institutional reparation for past harm, engagement will always be one sided and represent the agenda of the dominant epistemology. This form of tokenistic engagement is well entrenched in the “patient engagement enterprise”, a concept elucidated by Jennifer Johannesen in her talk: “The Trouble with Patient and Public Involvement”. She says that patient engagement will always/already neutralize ‘truth to power’ precisely *because* it is unethical and should therefore, not be done.

The patient engagement enterprise was not created for activists. On the contrary, institutions don’t open their doors to protest, they don’t appreciate when people speak truth to power, they don’t want to be held to account. (3)

By neutralizing the power imbalances still embedded in the system, many of these engagement frameworks that were not informed by critical analysis or theory sustain a myth that engagement or co/production is an unbiased, ahistorical solution to a complex, poly/vocal history of which many voices/perspectives are missing. I struggle with being complicit within the engagement enterprise, while trying to dismantle. The shape of my words and being, forever wounded by this compromise.

The dialectical tension between then/now or between activism/engagement, also illustrates the inside/outside concept that politicized people with lived experience are not inside the system's leadership or staff; they are always clients, service-users or people who exist outside of "knowledge-production"/epistemology and have nothing in common with those who work on the inside. Neither of these mythologies help us come together to attempt reparation and work collaboratively, in fact they perpetuate arbitrary divisive thinking and praxis.

If we treat engagement like customer service instead of like human rights advocacy, we will do market research just like companies and we will file complaints and desires into dead-end mechanisms, into archival graves and reports that never see the light of day. The social justice and liberation rhetoric that surrounds engagement, borrowed from decades of activism that precede government mandates and policies, dilutes the subversive grain of activists/advocates voices. The activist or advocate is now branded as a "change-maker", and "engaged patient" and told that they must co-produce with institutions and give up their "radical" values. The voice that is angry, tired and unwell that refuses to be managed by neutral benevolence, is slowly being drowned out in the false harmony of patient engagement. Rather than adopting a defensive stance, remembering and attending to past institutional and systemic harm is part of taking responsibility and remaining accountable; it creates opportunities for moving towards ethics.

Therefore, could ethical engagement be a commitment to critique as an act of love, to listening to madness speak truth-to-power, to finally admitting our complicity in reproducing the status quo, and learning from that discomfort?

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¹¹ This gesture of inclusion is described by the Ministry of Health and Long Term Care in Ontario as a “commitment to provide quality care that is centred on patients and driven by improving outcomes and satisfaction for those patients.” <http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/>